

**The childbearing experiences of
Chinese and Scottish women
in Scotland**

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I hereby declare that the thesis has been composed by me, it is my own work and it has not been submitted to any other body for any other certificates or professional qualifications.

Ngai Fen Cheung
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Transcription conventions

In the transcription of spoken data the following marks are used

() indicates recorder stopped and the conversation missed

[] gives researcher's explanation or notes

- marks a short pause.

+ illustrates longer pauses

+ +. extended longer pauses.

)(laugh / giggle.

I, interviewer

W, woman interviewee

W + **Roman numerals**, Chinese women

W + **alphabetic letters**, Scottish women

H. woman's husband

R, women's relatives

F, friends

F+ **Roman numerals**, Chinese friends

F + **alphabetic letters** Scottish friends

P, professionals or health workers

P+ **Roman numerals**, Chinese professionals

P + **alphabetic letters**, Scottish professionals

The transcriptions were recorded as faithfully as possible what was said and there was no tidying up the language used. Consequently there was some apparently ungrammatical forms, as well as occasional dialect forms in some extracts.

Abstract

My research questions are: 'How is childbearing constructed and experienced by Chinese and Scottish women having babies in Scotland?' and 'How may we explain any differences within and between the two groups of women'. The aims of the study are to further the understanding of cultural construction of 'choice' and 'control' over childbearing and to make some policy recommendations for the NHS maternity practices to improve women's experiences of childbearing, especially for Chinese women.

In the study I adopted a comparative approach. Four semi-structured interviews were carried out with each of 10 Chinese and 10 Scottish women and other unstructured talks and group discussion with 45 women's relatives, mothers, friends and health workers. This was combined with a literature based review of the history of childbearing practices, and supported by my participant observations as a midwife in China and in Scotland and as a Chinese mother giving birth to her first child in Scotland, through which I interpreted and made sense of the material I collected.

This study focuses on the analysis of the meanings that women gave to their childbearing experiences. Having children was meaningful to Scottish and Chinese women in Scotland in different ways which are related to their social positions, beliefs and practices involved and the change in social status on the birth of a child. Different meanings demand different coping strategies in healthy childbearing between Scottish and Chinese women. It supports much earlier evidence in literature that childbearing is socially shaped and culturally specific.

It develops further an understanding of the relationship between 'choice' and 'control'. Both Scottish and Chinese women in the study were in a changing 'theme' of struggle between autonomy and control — between the mind and the body. Chinese women tried to 'fit in' with what was 'normal' in the host culture but at the same time retained elements of their original cultural practices which are still meaningful to them in the new social environment. The issues of 'choice' and 'control' in childbearing to Chinese women are regulated by the safety of the mother, the concern for the new-born and postnatal practices of *zuo yuezi* (sitting in for the month). Although the issue of 'safety' in Britain may also occasionally outweigh the conflict with 'control' and 'choice', Scottish women take greater interest in their sense of control over their childbirth. 'Choice' and 'control' are therefore useful tools for them and for the other parties involved.

My study has filled an empirical gap in the literature by challenging the stereotypes of transcultural nursing models and providing new material about Chinese women in Scotland who seem not to have been studied before and whose needs may not be appreciated in Britain. It informs practice both in general and specific terms although some of them would require further testing. Such knowledge will add some new dimensions for health workers to relate with women so that they can facilitate a new dynamic and stimulating experience with the women they attend.

Part I

Social, cultural and medical background

Chapter 1

Introduction

This thesis touches on issues of Chinese and Scottish societies, medical systems, race and ethnicity, medical and midwifery practice and transcultural nursing in order to present the childbearing experiences of Chinese and Scottish women in Scotland. It consists of two main parts: extensive reviews of literature about social cultural and medical background (Ch 1-6) and analysis of interview data and issues arising (Ch 7-9). The theme which runs through the thesis is of childbearing as socially and culturally constructed.

Chapter 1 introduces the interests and concerns that have guided the study, and that are developed and expanded in the study. It is presented in four sections 1) background and research questions, 2) theme: childbearing as socially shaped and culturally specific, 3) contribution of this study to the knowledge and the practice, and 4) the outline of thesis.

1.1 Background and research questions

Before I came to Britain to study, I had worked as a 'barefoot-doctor' as well as a midwife in the villages in southern China for about five years. I was later fortunate to have an opportunity to go into midwifery training in Edinburgh from 1990 to 1992. While I was doing midwifery training in Edinburgh, I noticed that there were significant differences in birthing practices between the two cultures and societies. My experience as a midwife in China was different from my experience as a midwife in Scotland. Such awareness sparked the initial interest in my research and drew my attention to the range of childbearing experiences Chinese and Scottish women have in Scotland. This resulted in the study undertaken.

The childbirth experiences of Chinese women in Britain are different from what they could expect in their home country. During my eighteen month midwifery training in Scotland, I recorded in detail my reflections on what I observed. This has laid a foundation for me to understand the culture of childbirth in Scotland. The idea of a comparative study of the childbearing and childbirth experience of Chinese and Scottish women in Scotland was thus formed. My questions were:

- 1 How is childbearing constructed by Chinese and Scottish women having babies in Scotland?
- 2 How is childbearing experienced by Chinese and Scottish women in Scottish hospitals?
- 3 How may we explain any differences in the above both within and between the two groups?

My study focuses on the experiences of these two sets of women of pregnancy, birth and postnatal care. Such a comparative study can throw light on questions of ethnicity and ethnic identities in the UK and in the British National Health Service (NHS), as well as providing useful insights as to how midwifery and/or medical practice might be improved for Chinese women in Scotland. I also compare my experience as a midwife in Scotland with that in southern China in order to make some contribution to social science knowledge about the social and cultural construction of childbearing.

The starting point of the study is that individual women's experiences of childbearing are seen in the context of their particular social and cultural setting. I use the 'site', 'scene' and 'cast' of childbearing and childbirth to address broader questions about knowledge of the women in relation to childbirth, the society in general, medical staff and midwives, and thus to answer the question of how childbearing has been socially and culturally constructed. The bases of the construction are the ideologies of the doctors, the midwives, the mothers and the wider Scottish and Chinese societies. The study has illustrated the implications of obstetric and midwifery technology for women, their families, midwives, doctors, the culture and the society itself.

Childbearing is not only a bio-physiological but also a social and cultural process (See §1.2). Hence many factors come into play, for example, the factors of the organisational structure, ethnicity, institutional racism, multiculturalism in the NHS, cultural influences, ritual and functions of midwifery as a system of behaviour (Freidson 1970: 41-2). My study examines the social and cultural construction of medicine, obstetrics and midwifery as discussed in the contemporary sociological medical literature.

This study has involved extensive reviews of disparate literature plus interviews with Scottish and Chinese women in Scotland. Over the years I have had

first hand experience through participant and non-participant field observations of childbearing in China and in Scotland; some of these observations are also included. The research design and methodology of this study are discussed in detail in Chapter two.

My primary empirical focus is on the experiences of Chinese and Scottish women having babies in Scotland, which represents a gap in the literature on childbirth. This is a fairly new area of sociological study. The study aims to analyse the cultural diversity in childbearing and to explore the social and cultural impact of medical practice on women's experience during pregnancy, birthing and recovery. It is intended to provide empirical evidence of the needs and birthing experiences of women in Scotland in order to further the understanding of the cultural construction of childbearing which might lead to improvement of NHS maternity services especially for Chinese women.

The analysis of experience in the study is objective in terms of the constructionism and cultural relativism, as the researcher is trying not to make any value judgements about the women, their views and birthing practices under investigation. The researcher herself and the women under investigation 'have deconstructed as objective entities, and shown to be categories of thought' (Hastrup & Hervik 1994: 1).

1.2 Theme: childbearing as socially shaped and culturally specific

The theme of social and cultural shaping childbearing is to elucidate the process from individual childbearing experiences to the production of knowledge that provides a better understanding of the process and practices of childbearing. This framework is used to capture the social realities of the different ways of experiencing childbearing in Scotland, that are fluid and difficult to express in words but it may, at the same time, create an illusion of patterns, that is beyond the intention of this research about the people under study.

This section is subdivided into 1) social organisations and institution, 2) social choice and control, 3) cultural meanings of childbearing and 4) related researches on the social and cultural shaping of childbearing.

1.2.1 Social organisations and institutions

Childbearing is a biological and physiological process and, at the same time, a cultural and social process (Jordan 1978: 1-10). The term childbearing in this study covers not only pregnancy, parturition and postpartum recovery but also the fuller experience and meanings associated with having babies. The 'same' biophysiological processes can be experienced differently by different women and have different meanings. Both the biophysiological process and its meanings can be altered by social and cultural practices and individual subjectivity.

For medical professionals, childbearing is mainly seen as a biophysiological process. Their main interests are on diagnosing pathological complications of childbearing. This is especially so in the hospitalisation of childbirth in Western industrial societies, although hospitalisation for childbirth has greatly influenced the birthing practices of many societies throughout the world in the past century (Oakley 1984, Wagner 1994). One may argue that the institutionalisation of childbearing is itself not the problem—childbearing could be seen as institutionalised in one way or another in all societies. What is problematic are the ways in which a medical model of childbearing is perceived and constructed. Therefore I find it equally important to see childbearing from the point of view of the medical and midwifery professionals and how their perception of childbearing and their practices shape the experiences of women in childbearing.

Through long residence among people of another culture, anthropologists approach childbearing in a way which reaches beyond the understanding of the universal bio-physiological process of childbearing. Such an understanding is what is needed for scholars who wish to understand childbearing in their own societies. Childbearing is a pivot in the life cycle of humankind. It is symbolically signified in different ways by all human societies; no human society has been found to have such an event without any symbolism and rituals attached (Jordan 1978, MacCormack 1982, Yearley 1997). Symbols and rituals signify all events directly related to childbearing: from marriage to conception, from the birth of a child to the naming of a child. These symbols and rituals are indispensable to the cohesion and continuation of a society. One can also argue that medical technology itself is a necessary ritual in cultures where it is used in childbirth; amongst other things it acts to ensure that the way in which a child is born is acceptable to that culture.

It is not only childbearing that is regulated within specific institutions but also the practices and meanings surrounding childbearing differ in different cultures (Jordan 1978, Yearley 1997: 23, Eisenbruch 1983, Dick-Read 1942, Snaith & Coxon 1969, Oakley 1980, 1984, Odent 1984, 1990, Kitzinger 1977, 1982, 1984, Macintyre 1977). Culture informs group members' world view and how to behave by the use of customs, symbols, language, art and ritual. It gives them a set of explicit and implicit meanings associated with the event of childbearing, notwithstanding that these communities and their cultures are in constant contact and change.

Childbearing is a social process, sanctioned by the society in which it takes place. Even in today's industrial societies where pre-marital or extra-marital childbearing has become common, childbearing has still to be authorised by the society in different ways. Therefore childbearing is a social institution in which there are different rules, most obviously religious observance, taboos, legal requirements to have medical attendance or registration of a birth, etc. to regulate the behaviour of the members of a society around childbearing. Here symbolism and rituals are the means by which the social rules of childbearing are implemented and the social institution of childbearing is consolidated.

In Scotland and China alike, there are social divisions of labour in childbearing. Childbirth, though exclusive to women and attended mostly by midwives or nurses, is controlled by many professional groups who are predominantly men — politicians, lawyers, health service managers, obstetricians, anaesthetists, microbiologist and paediatricians. There are small number of women within these groups, but collectively they may be said to express a masculine view of childbirth (Bates 1997: 132). In both societies, as in most societies of the world, these social divisions of labour and hierarchies are perceived as gendered, but in different ways. The experiences of women in childbearing divagate a great deal of such perception.

At the micro level, a birth will change the existing social structure by the appearance of new parenthood, new families and new social relationships. Such a social change takes place immediately a new life is conceived and will become a new social reality when the new-born is finally accepted by the society, through naming or other rituals. Sometimes the process of childbearing is seen as a transitional period of a social reality. Such a transitional period is ritually important in any given culture (Yearley 1997, Jeffery et al. 1989: 72-120, Homans 1982). In many cultures,

childbearing is seen as polluting and dangerous (Ahern 1978c, Jeffery et al 1989: 105-107). This in effect marks out such a transitional period as a social uncertainty. Rituals are required for members of the society to go through this uncertainty. It is not surprising that in such a transitional period, various social actors of different social and power relationships are involved in our societies today.

The study of these relationships leads to the discussion of social choice and control, cultural meanings of childbearing and related research on the social and cultural shaping of childbearing.

1.2.2 Social choice and control

Choice and control are reoccurring themes on the midwifery and sociological literature on childbearing and they arise in the context of the particular institutional setting. There has been an increasing emphasis since the early 1980s on the rhetoric of consumers' choice and control in childbearing in the UK (DoH 1993a, Campbell & Macfarlane 1987, Tew 1990, 1995, Chalmers et al 1989, Sandall 1995) as the result either of a feminist inspired paradigm of equal partnership between health workers and women and/or the creation of a new midwifery elite (Sandall 1995). The issues of choice and control are thoroughly reviewed in Chapter 5 of this study. The aim of this discussion is to link conflict and tension around choice and control to the framework of childbirth as socially shaped and cultural specific.

The concept of social construction of choice and control in childbearing is well known among many social scientists (Giger & Davidhizar 1995: 61-88, MacCormack 1982: 1-21, Macintyre 1977: 18, Sandall 1995). Choice and control cannot be understood outside the context in which they are addressed. Their meanings are an integrated and interrelated part of a specific culture under discussion but at the same time 'no culture ... is static' (Schott & Henley 1996: xvi). The rules, customs and restrictions regarding the pregnant women's diet, sexual activity and conduct in the other societies are also 'the subject of social controls and sanctions' (Macintyre 1977: 18).

Similarly, women's demands for choice and control in childbearing in Euro-American societies are the response to modern obstetric technology and the non-personal medical approach. Thus one of the keys to unlock the meanings of choice and control in childbearing in the Western medical context is women's perception of and reactions to obstetric technology and the experiences of their childbirth. Although the

two sets of women studied are in Scotland, the same social and cultural setting, their different cultural backgrounds give them different expectations, choices and experiences. These differences are examples of the social and cultural construction of childbirth. Chinese women's experiences of childbirth are changing in the host culture and society and their different expectations, choices and experiences have also brought changes to the host birthing culture.

The issues of choice and control are much more complicated than they appear. 'Choice' and 'control' imply a hierarchical relationship. They are correlated but not necessarily reciprocal. 'Choice' means an option and implies a dialectical relationship of consent from the other parties involved. Choice does not necessarily mean having control. The discussion of 'choice' and 'control' in childbearing involves many social actors, such as women, health workers, technology, the wider social context, woman's body and baby etc. This is further discussed in §10.4.

The ideology of women's right to choose and to control their own bodies has been a popular theme in the last three decades. It brings up problems of what and how much information women should have, how much control they can retain and whether they are assertive enough to be able to make appropriate choices. In this sense, the balance of power between women and their carers must be addressed before choices and control become realistic (Mander 1993a & b).

The discussion of choice and control is linked to the discussion of the social divisions of labour and gender hierarchies which cut within and between groups of actors. It leads to the issue of autonomy in midwifery and maternity care (Mander 1993a). 'Autonomy' in childbearing is not synonymous with 'control' and 'choice'. The question of autonomy is the question of information retained and used by different actors. The power of autonomy here lodges in the acquisition of knowledge. Therefore 'choice' and 'control' are a field of relations from which power is both constituted and resisted. 'Choice' and 'control' are useful tools for all contesting actors concerned with childbearing to manipulate them in order to enhance their own power or control.

1.2.3 Cultural meanings of childbearing

Both 'society' and 'culture' are continuously redefined in the discourse of social sciences but an important aspect of the redefinition that has come to the surface is the constant dialectical relationship between subjectivity and objectivity, and between collectivity and individuality. This can be read from the works on the theories

of culture (Haferkamp 1989, Dirks et al 1994, Alexander & Seidman 1990: 26). The concept that culture is political is also generally acknowledged (Dirks et al 1994: 3-11, Barnard & Spencer 1996: 141-142).

Culture is, materialistically speaking, the values, beliefs, norms and practices of a particular group that are learnt and shared by members of the same cultural group and guide their thinking, decisions and action in a patterned way, according to Leininger (1978: 7 & 12) and Giger and Davidhizar (1995:3), the leaders of transcultural nursing. The notion of culture has recently been undergoing rethinking. The concept of culture has, ideologically, been expanded to what makes sense to people in that particular cultural context. In other words, culture is the way experience is construed (Geertz 1973, Dirks et al. 1994: 4 & 22, Alexander & Seidman 1990: 25). It constitutes the terrain of meaning and feeling.

The culture of childbearing provides a tool for us to understand the motives and meanings of social behaviour. The conceptualisation of childbearing in a society constitutes an important indicator of its childbearing system and its culturally specific meanings. The notions or the meanings of that society sometimes generate a systematic configuration of childbearing practices which are internally consistent and mutually dependent on one another for support.

Childbearing occurs in a social context and has a different meaning for different people (Page 1988: 251). Cultural variations have been observed in various studies of childbearing. According to Jordan (1978: 34), childbirth is a medical procedure in the United States, a stressful but normal part of family life in Yucatan, a natural process in Holland and an intensely personal fulfilling achievement in Sweden. Similar findings as that in Yucatan are also presented by Jeffery et al (1989) in India and in Kitzinger (1982) in Jamaica. These findings have illustrated well that what is appropriate in one cultural birthing system may be entirely inappropriate in another. They have provided us with the resources for a better understanding of the socially shaped and culturally specific construction of childbearing.

The distinction between 'culture' and 'nature' is analytic and dialectical in many ways. The overlap between these two polarities is complex. When I entered midwifery training in Scotland, I first heard about the idea and practice of 'natural childbirth' in Euro-American societies. I found this concept fascinating, but also felt that it did not address the question of different cultural rules and social practices in childbirth in each society. One cannot help asking: what is natural and what is not?

In modern urban China, the model of hospitalisation of childbirth is much more favoured than home delivery and it is obviously looked upon as much more 'cultured' in terms of the advance of technology and promoted by the state and the 'educated'. In Europe, modern technology in midwifery has also meant technological achievement in people's handling of childbirth. Therefore it can be argued that a 'natural childbirth' is another strategy used by people to resist non-personalised medical intervention in childbearing. The idea of a 'natural childbirth' simply strikes a biological note in the choir of cultural definitions, rules and social actions of childbirth in human societies.

One specific example of cultural variations concerns the attitude and approach towards labour pain. Although labour pain is a universal biophysiological process, it can be experienced differently by different women and have different meanings for them. The culture and socially acceptable way in developing countries are to withhold analgesics and anaesthetics in normal labour in the cases of Yucatan (Jordan 1978), India (Jeffery et al 1989) and China (Cheung 1994, Kleinman & Kleinman 1985). Women in those countries tend to go through labour without pain relief, relying on local ritual, self control and a local support network. In developed countries analgesics and anaesthetic are readily available. The extent of the reliance on pharmaceutical means in the natural process of childbirth is dependent on local definitions and interpretations of labour pain; for example, the Dutch system does not normally use medication to control labour pain (Jordan 1978: 53, Mander 1995) while pharmaceutical pain relief is medically prescribed in the USA (Jordan 1978: 55) and in the UK (Chamberlain & Steer 1993, Steer 1993a & b, Wright 1993, Niven 1994, CRAG Working Group on Maternity Services 1995).

Childbearing is also affected by cultural values and social practices which inform individuals about how to view the event, how to experience it emotionally and how to behave in response to other people and the world they live in (Yearley 1997). Medicalisation of childbearing brings childbirth from home to hospital from the 1970s on the grounds of safety, which is not supported by the available evidence (Campbell 1997, Campbell & Macfarlane 1987), and then the consumers' demand of the move from hospital to home in 1990s. These changes are the reflection of different interpretation, variation and justification of a society at a given period of time.

In line with existing studies, I see society as something institutional and organisational. Chinese women in Scotland, as any other minority ethnic group, have

their childbearing experience against the Scottish institutional and organisational background. However within this social structure, they have room to manoeuvre, to follow practices and beliefs which are comfortable for them as social and cultural beings. Here, their original cultural background, their past experience and history have come into play in their 'lived realities' as members of a migrant community in Britain. NHS policies need to be aware of such adjustments of women from such communities. As I demonstrate, adjustments of social and professional institutions in childbearing have not only taken place among the Chinese women in Scotland, but also among the Scottish women and health workers.

1.2.4 Related research on the social and cultural shaping of childbearing

Social and cultural shaping of childbearing has been addressed by some social scientists and transcultural health professionals (Oakley 1980, 1984, Kitzinger 1984, 1987, Hunt & Symonds 1995, McIntosh 1986, 1989, Yearley 1997, Leininger 1978, Giger & Davidhizar 1995, Schott & Henley 1996). Some of them highlighted the socio-cultural aspects of childbearing by examining birthing practices in different countries (Jordan 1978, 1993, Jeffery et al 1989, MacCormack 1982, Gideon 1962) and across cultures within the same country or different countries (Jordan 1978, 1993, Homans 1982, 1983, 1985, Kitzinger 1982).

Research on the social and cultural construction of childbearing across cultures is limited. Jordan (1978) breaks new ground in her contribution of cross cultural comparison to the development of maternity policies which could accommodate cultural values. She used anthropological participation as the methodological device and participated mainly as an observer and sometimes as a helping hand during the birth to give her access to the 'knowing how' of birth and to provide the foundations for a holistic conceptualisation of the birth process (Jordan 1978: 8-10). She considers that the insider's simple statement is not sufficient for an adequate understanding of how the system works because birthing is characterised by a high degree of 'intimacy' and 'interaction complexity where people know how to do without necessarily being able to talk about the details of what they do'. Jordan's notion of participation meant 'something more comprehensive than physical co-presence with, or joining in the activities' (Jordan 1978: 9) of the people under study. She used a comparative analysis of birthing systems addressing the interface between what is biological and what is social and cultural in the process of childbirth, which

she called 'biosocial framework'. She concluded that birthing practices should be designed as 'system-orientated', 'crossculturally' and 'biosocially' orientated in order to make childbirth emotionally rich and medically safe (Jordan 1978: 88-89).

Jordan focused on how she perceived the four systems as an anthropologist and investigated the range of the biosocial production of childbirth practices across different systems. Her emphasis on a 'biosocial' interpretation of birth practices has added to an understanding of childbirth as socially shaped and culturally specific and provided some valuable cross-cultural material in this regard. My study builds on her findings and uses social and cultural shaping of childbearing as the framework. The method used in the study extends to include my own inside observations as a midwife and a mother having her first baby in Scotland to address the social and cultural configuration of childbearing practice and women's experience of childbearing to expose the range of human variation in childbearing.

Homans (1982, 1985) interviewed 39 South Asian women migrants and 39 British women at hospital booking clinics in a British Midlands industrial city in 1977. Twenty six of each group were interviewed a second time at their eighth month of pregnancy. Although she compared the status, experience and reaction of pregnant women from two different ethnic backgrounds in the *same British setting*, her emphasis is on their differences related to 'their class and cultural background together with the strength of their lay support system' (Homans 1985: 160). The social construction of pregnancy experience of the women in her study further supported Jordan's argument of the biosocial nature of childbirth. Her study has made some substantial sociological contribution to the understanding of South Asian migrants' experiences of pregnancy in Britain and offered me a window to see and compare with another ethnic minority group's experience of being pregnant in the UK.

In my view the same setting in the study of British and Asian women in Homans' study was assumed and had not been questioned as problematic. As the result of this Homans (1982: 258) cited her participants' accounts of their previous birthing and postnatal experiences to support her argument that the event of childbirth separated the women from their familiar social and domestic environment and they required certain forms or rituals to re-integrate themselves back to society in Britain. What was stated by these Asian women may not necessarily happen in Britain as 77% of them were born outside Britain and 65% of them had lived in that city less than six years.

In line with Homan's research, my study has investigated the childbearing experience of a group of migrant women with that of British women having babies in Britain but it differs in many ways. It deals not only with the experience of pregnancy but with that of birth and the postnatal period. This study illustrates especially Chinese women's indigenous viewpoints, beliefs, and practices about childbearing and emphasises the diversity and fluidity of their childbearing experiences and the different cultural meanings associated with having babies in Britain.

Transcultural nursing anthropologists (Leininger 1978, Giger & Davidhizar 1995) have endeavoured to identify, explicate and expound the different cultures within the same institutional setting. They tried to identify a patterned behaviour and expressions that were learned and shared and that guided thinking, decisions and actions of different ethnic groups (Giger & Davidhizar 1995: 3-4). They have used a comparative perspective of at least two or more designated cultures in order to determine the major care features and the health services of cultures (Leininger 1978: 53) and to make professional nursing knowledge and practices culturally based, culturally conceptualised, culturally planned, and culturally operationalised (Leininger 1978: 12).

Based on Leininger's transcultural nursing work, Giger and Davidhizar (1995: xi, 8-9, 127) argued that cultures are evident in communication, spatial relationships and needs, social organisation, time orientation, and ability or desire to control environmental control and biological differences. They believed that cultural insights and a deeper appreciation for human life and value can be achieved through an assessment of the models of these cultural phenomena in all cultural groups (Leininger 1978: 39, Giger & Davidhizar 1995: 9). Their models are based on a belief of culture's durability and internal coherence and consistency. But some current social science studies suggest that timeless traditions may turn out to have been 'invented' (Hobsbawm & Ranger 1983, Dirks et al 1994: 7). Culture is made up of multiple discourses, occasionally coming together in large systemic configuration but more often coexisting within dynamic fields of interaction and conflict (Dirks et al 1994: 3-4). Although the diversity and dynamic nature of a culture are acknowledged, the models of transcultural nursing tended to search for something homogeneous within each culture and fail to capture the changes and variations within a culture and cultures over time in response to new situations and pressure. Thus they encouraged stereotyped inaccurate information about other groups. Any notion of this rigid model of cultural behaviour to which nursing and midwifery practice should orient is

problematic (§6.4) because, as has been argued, no set of behaviour or ‘no set of “facts” applies to any one individual’ (Schott & Henley 1996: xvi). My findings did not support this aspect of the transcultural nursing model well; rather they support to some extent the argument of invention of tradition/ culture and the arguments that the culture is in the process of changing when it is in contact with other cultures.

Culture changes have a bearing on meanings and medical practice. Henley and Schott (1996: xvi) attempted to illustrate the dynamics of people and cultures from their literature research and stated that nobody would like to be treated as ‘a stereotyped bundle of facts’. In every culture, individuals make sense according to their environment and their own personality. They suggested the best means to identify individual needs is to ask and listen to the client herself to determine her needs, her world view, her values and beliefs and where she sees herself in relation to cultural changes (Henley & Schott 1996: 61-68). There is a problem here in that some minority ethnic groups might feel vulnerable and reluctant to talk about their needs when they are in a marginal position and their beliefs, customs, religion are portrayed in negative stereotypes and distortions. This cultural tactic of reluctance to talk about their problems and the preference for self-help within their community has been observed in Chinese (Chan 1988: 7) and other Asian communities (Henley 1979).

1.3 Contribution of this study

My initial interest in the differences in childbirth between the Scottish and the Chinese has brought me a wider and richer understanding of the social and cultural shaping of childbearing in human societies. Before I embarked on the investigation of the childbearing experiences of Scottish and Chinese women in Scotland, I had little awareness that my investigation was far more significant than a mere interest in the differences.

Comparing the study with the available literature, the design, method and focus of study are different. My interest has been in the individual childbearing experiences of women from two cultural backgrounds in Scotland, i.e. Chinese and Scottish women in Scottish society. My findings have led me to see childbirth as changing for both the Chinese and the Scottish women, especially for Chinese women, in response to the pressure of cultural confrontations, integration and many other influencing factors beside their cultural beliefs and behaviour and social class in Britain. The method of this study will be discussed in Chapter 2. My own cultural position provides me with some insider’s understanding of the women under

investigation. These are particular in the practice of participant observation in sociological enquiries. The study compares the childbearing experiences of women across cultural and disciplinary boundaries in a common contemporary society using individual, literary and historical sources. It focuses on the analysis of the meanings that women give to their childbearing experiences in response to the new situation and pressure in Scotland 'crossculturally' and 'biosocially' in Jordan's terms or 'transculturally' in Leininger's terms.

The investigation has further broadened my view of childbearing especially when I based my study on the literature and combined the contemporary perspective with a historical and literary perspective. In my investigation I have found no substantial works comparing Chinese and Scottish women's experiences of childbearing. The Chinese informants' accounts to encompass both British and Chinese norms inform notions of how cultures of both upbringing and adult life construct expectations of childbearing and childbearing experiences. The key contribution of my study in term of how we understand the social and cultural constructed childbearing is that it has revealed tensions and changes in how childbearing is constructed in each group.

The traditional childbearing practices of Chinese women in Scotland are undergoing changes through time, but these traditional practices are more resilient than most people suspect because of their importance to Chinese women. Some Chinese individuals are experiencing more extensive cultural conflicts and changes as they try to identify themselves with the new culture, others are experiencing gradual changes over a period of time consciously or unconsciously. On the whole the Chinese women in the study have reconstructed their childbearing experience by accepting some British norms alongside their retention of some of their own.

Both Chinese and Scottish women in the study are in a changing theme of struggle between the mind and the body. Choice implies a set of options for all actors concerned with childbearing. An option chosen by an actor means the loss of control of the others, which means control. Women's personal control is dependent upon availability of resources and options that allow choice. The cultural categories of 'choice' and 'control' in childbearing are one of the sub-issues on which this project focused. They are looked into from an interpretation of culture as the construction of power, from the hierarchical social and gender divisions of labour. My study suggests

that even the hotly-debated issues of 'choice' and 'control' in the sociological and midwifery circles are poorly defined.

In addition this research has clearly filled an empirical gap in the literature by providing new material about Chinese women in Scotland who have not been studied before and whose needs may not be appreciated in the NHS. It informs practice both in general and specific terms. Awareness of the social and cultural construction of childbearing would add some new dimension for health workers to relate with women so that they can facilitate a new dynamic and stimulating experience with the women they attend.

1.4 Outline of the thesis

The thesis consists of two main parts. Part I introduces the interests and concerns of the study (Ch 1-2) and extensive reviews of literature and cultural backgrounds (Ch3-6). Part II focuses on the meanings of childbirth, relationship between women and health workers, the ideologies of autonomy and control (Ch7-9), and further analyses and the conclusion of interview data and issues identified from the literature reviews (Ch 10).

Chapter 1 outlines the interest and some of the basic theoretical concerns that have guided the study. The guidelines proposed are the research criteria that is developed and expanded in the rest of the study, particularly in relation to cultural shaping of childbearing experience. From this starting point Chapter 2 introduces the qualitative method adopted for this study, which has combined historical, textual and contemporary fieldwork approaches and involved mainly the techniques of participant observations, semi-structured and unstructured informal interviews.

Chapter 3, 4 and 5 examine the historical, social and medical background and context of childbearing of two different societies: the Scottish and the Chinese and explore some aspects of debates about obstetric technology and women's experience of childbearing. Part of the concern of these chapters is to find the link between women's childbearing experiences and their cultures and beliefs. Chapter 6 unpacks the experience of Chinese immigrants and their lives in Britain. It pays particular attention to the issues and debates about their identity, ethnicity, racism and the reasons why certain problems were perceived.

Chapter 7, 8 & 9 of Part II are the main findings of this study. They focus on the meanings of childbearing, the relationship between women and health workers, ideologies of choice and control arising from the empirical material of this study. In this context women's experiences of having babies in Scotland are compared. These chapters look at the differences in the conceptions, beliefs, health seeking behaviours and birthing practices including pregnancy, birthing and postnatal convalescence of these two groups of women and set out to explain the differences between them.

Chapter 10 analyses the data further and concludes that the meaning of having children is socially and culturally defined. Chinese women in Scotland have reconstructed their childbearing experiences while partly accepting the birthing culture of the host country. Both Chinese and Scottish women are in a changing theme of struggle between autonomy and control, between the mind and the body. The childbearing experiences of individual Scottish and Chinese woman are cultural in the sense of the different meanings they have. These experiences are not only dependent on the Scottish and Chinese institutions but they are also useful or constructive to these institutions to provide sensitive and cultural specific maternity services. Both groups of women are constantly seeking strategies through their childbearing experiences. These strategies form the contemporary cultures of childbearing.

The study illustrates the variations, diversity and dynamic nature of the participants and the institutional child birthing culture within this common setting. Scottish obstetric practices are under pressure to adjust to changing views and needs of the women involved in childbirth, while the Chinese migrants' childbearing beliefs and practices in Scotland are changing under the influence of Scottish obstetric culture. The social and cultural construction of childbearing becomes more conspicuous through this cross-cultural comparison. The findings of this study further support and enrich the argument that childbearing is socially organised and culturally produced.

Chapter 2

Research design and methods

A comparative qualitative method is adopted for this study to investigate the experiences of Chinese and Scottish women having children in Scotland. This investigation is combined with a literature based review of the historical reflections on childbearing practices and with records of my own experiences as a midwife in both societies. The techniques for data collection are primarily semi-structured and some unstructured informal interviews and supported by my own participant observations through which I interpreted and made sense of the other material. The discussion of the method is divided into six sections: (1) overview of research design, (2) participant observations, (3) the pilot study and lessons learned, (4) the main semi-structured interviews with the participating women, (5) the other unstructured interviews with relatives, friends and professionals, (6) data analysis, (7) reflexivity.

2.1 Overview of research design

There are six features of the research design in this study. They are the literature reviews, participant observations, the two case comparative method, four semi-structured interviews with each of the Chinese and Scottish women having babies in Scotland, further unstructured interviews with their relatives, friends and health workers, and finally the analytical framework of cultural shaping of childbearing.

The first feature of the research design is the extensive nature of the literature review which was used to determine what was already known on the topic, what needed to be addressed further in order to develop sharper and more insightful questions about the topic, and how to design the research. The review is broad ranging in order to capture the complexity of women's experiences of childbearing. It touches on aspects of Chinese and Scottish societies, their medical systems, gender, race and ethnicity, and medical and midwifery practice. Each aspect has a very extensive literature. Because such a wide ranging literature review was necessary, it is viewed as an integral part of the method used in this study. The detailed literature reviews are presented in Chapters 3, 4, 5 and 6 which are, where relevant, supported

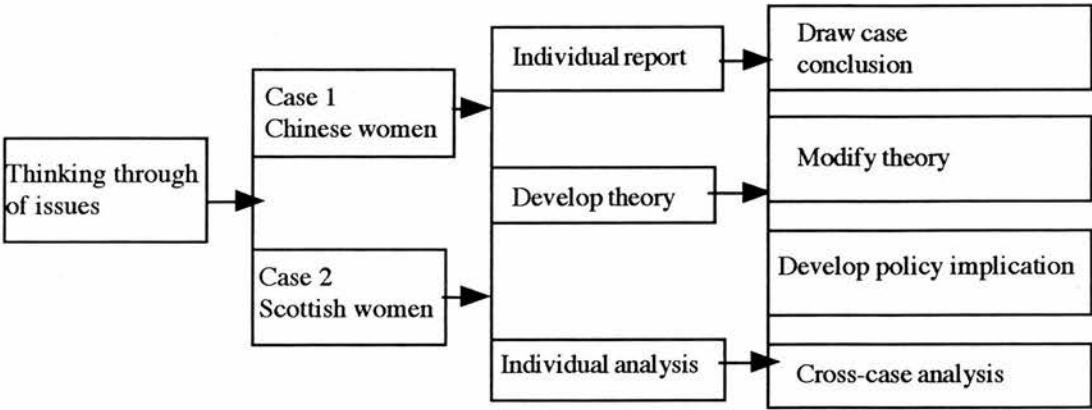
by my participant observations as a Chinese health worker in China, a migrant and a researcher in Britain.

The literature review seems to confirm that there had never been any study done before about childbearing experiences and birthing practices of Chinese and Scottish women in Britain. There is a gap in our knowledge especially about the experience of Chinese women having babies in Scotland. It indicated that this research is fundamental if we are to know these women's view on service provision and to explore their particular needs in childbearing and how the care needed is provided.

The second feature of the research design is that it draws on some participant observation (Burgess 1982) from my experiences as a midwife in China and Scotland and a Chinese migrant who has given birth in Scotland (§2.2).

The third feature of the research design is its use of a two case comparative study method, (Yin 1984: 27-54) drawing on a variety of information — documents, interviews, participant observations, some ethnographic and phenomenological data. The design of this comparative case study approach is illustrated in Figure 1.

Figure 1: 2-case study network



The collection and analysis of data were comparative — enabling contrasts to be drawn between how Scottish and Chinese women experience childbearing as well as similarities and differences within the two groups. The comparative analysis of the women's experience facilitates a more comprehensive study of the range of women's experiential reality seen in terms of changing values rather than fixed meanings of childbearing and childbearing practices. In the process of investigation and comparison, differences between the experiences of the women emerge and point to possible causes of different childbearing perceptions, beliefs and practices which can

inform the medical, social and anthropological knowledge. The comparative method provides a more robust and compelling basis for a discussion of the specific issues facing the Chinese women migrants as an ethnic minority in the NHS than would a study which only looked at the experiences on Chinese women.

The fourth feature of the research design is that data were collected from both groups through repeat semi-structured interviews (§2.4). These interviews were designed, on the one hand, to obtain some reflexive knowledge to understand and share the women's experience and, on the other hand, to follow up any topics or issues arising or missed in the previous interview. What I have termed 'semi-structured' means that there were a number of open ended questions and opportunities for expansive responses. The interview schedule sought to explore various sociological issues in childbearing — such as family life and community, health and institutional birth (Appendix I). Background data on the women in the study were obtained from hospital records, medical notes, midwives' and nurses' notes, official statistics, government census, materials about antenatal classes, three-week-cycle hospital menus, parenthood classes, leaflets on breast and bottle feeding.

Fifth, further unstructured interviews were conducted with relatives, friends and health workers (§2.5). These interviews were designed to encourage free expression, to supplement the main interviews and to understand women's experience from a third party's perspective. They were carried out with a general topic guideline but guided by the issues raised in the interviews that are significant or meaningful to the interviewees. The interview topic guide reminded me of the areas to be covered in my investigation and was also used as a form for recording the answers.

Last but not least, the analytical framework utilised in this study had two elements. First the focus is on 'childbearing'. This concept encompasses not only women's experiences of the three stages of pregnancy, birth and postpartum recovery, but also the wider cultural and medical context, including gender relations, which give meaning to these experiences. Second, and related, childbearing is understood to be socially and culturally constructed (§1.2).

2.2 Participant observation

Participant observation is also known as ethnography, field work or field research (Hughes 1960: v, xiii- xiv, Junker: 1960, Gans 1982, Burgess 1982, Field 1989: 81). It covers, in a wide sense, varieties of participation, observation, informal

interviewing and any other methods that are available to the researcher to tackle a research problem. A participant observer adopts a multitude of social roles (Hughes 1960: xiv, Junker 1960: 32, 69, Gans 1982: 54), trying to understand people under investigation objectively from their own frame of reference and/or to understand them subjectively through the observer's own involvement with the culture. It is through this process of interpretation of the experienced culture that the observer discovers meanings in the data (Bruyn 1966: 27-28). In a narrow sense according to Seymour-Smith (1986: 216), participant observation now may only mean one of a set of research techniques, not necessarily including interviews.

Critics of participant observation point to its possible biases, the lack of adequate criteria of proof and its tendency to produce purely descriptive accounts. Various writers suggested ways to overcome the limitation of this approach. Malinowski advocated extensive periods of fieldwork to minimise the interfering effects of the fieldworker's presence and to permit a full appreciation of cultural meanings and the social structure of the group with all its functional interrelation between customs and beliefs (cited on Seymour-Smith 1986: 216). Various writers suggest the use of diverse methods to tackle a research problem and to assess the validity of the research, for example, Stacey's (1969) 'combined operations', Denzin's (1970) 'triangulation', and Burgess's (1982) 'multiple strategies'. They hold one thing in common that the application of multiple sets of data, strategies and theories can provide a depth of insight and interpretative material which are difficult or impossible to gather using other research methods.

To understand women's experiences of childbearing demands a degree of personal involvement, which involves many varieties of direct participation and observation of the event under investigation. My own experiences as a midwife in China and Scotland provided me with the initial impetus and motivation for my study. My experiences as a midwife and mother in Scotland were rather less important as a source of data as this study is primarily interview-based. In the context of the study itself, the greatest significance of my own participant observations and experiences was as a filter through which I interpreted and made sense of the material I collected.

In my study I have mainly drawn on three types of observations (Junker 1960, Gans 1982). The first one is my total participation as an actor in childbearing — as a health worker in both cultural settings and as a Chinese migrant woman who grew up in the mainland China and had her first baby in Britain. Such an immersion allowed me to hear, see, and experience reality much as the Chinese participants in my study

do. As a midwife in China and a midwife in Scotland I noted, asked questions about, and compared the phenomenon and different practices I encountered, in various kinds of settings. My own cultural position, as a Chinese midwife, a migrant and mother, provides me with more understanding of the Chinese women under investigation.

The second type of participant observations used in this study is that of research participant observation. I played an actor or participant role in the study but psychologically I tried to be outside the situation, deliberately detached in order to be able to observe objectively. I often asked questions with overt purposes of which my respondents were unlikely to be aware and withheld my personal response to the social setting in order not to overly influence their response. In this sense the research participant observation is deceiving people about my feelings and motives in order to get more authentic data. However, I was open and honest to the people under study about my research aims at the beginning.

The third type of participant observations involved is that of the total observer without any personal involvement, or non-participant in the situation under study. This occurred for example as I listened, observed and interpreted the interactions, activities and dialogues in the staff sitting room, the antenatal, postnatal and labour wards. This type of observation also applies to the observations made as a resident in Scotland since October 1985 and as a visitor for seven weeks in China in 1997 and 1999. It can be argued that this type of observation is strictly illusory because the complete detachment of the total observer in practice is impossible.

The distinction between these three types of observations identified may not be clear cut because I often found myself shifting through time from one role to another, which is further discussed in §2.7.2. Being a total participant as a Chinese woman, a midwife and a mother affords me a depth of interpretative insight material that is difficult to gather by the other research methods. At the same time the role of total participant made it impossible for me to play the roles of the participant observer and total observer, to be more detached from the subject and focused on my study. In the end I discovered that I could only play one role for a short time. On the whole my priority in this study was as an observer first and then a participant.

While I would insist on dual values of the insider's and the outsider's view points, my study has provided both perspectives. I studied Chinese women in Scotland as a Chinese woman— an insider —, and write for English speaking readers, the outsiders. But I study Scottish women as an outsider culturally with my

own overlapping experiences of the Scottish birthing and midwifery culture. In the context of the two the health systems, I was perceived as an insider in those five Chinese villages as a barefoot doctor but an outsider to the villagers as I was an urban youth; I am an insider as a midwife in Scotland but an outsider at the same time as a Chinese woman. My viewpoint as an outsider within has greatly facilitated my ability to assist Chinese migrants in the understanding of Scottish birthing culture. I am therefore able to discuss issues of childbearing as a health worker in both settings.

The recording of these three types of observations took largely the forms of personal diary and clinic records. Even though the recording of my observations as a barefoot doctor in China were done long before this study, they were recorded in a similar format as I used for the rest of the study, namely in daily diary while my memory was still fresh. In each entry I gave an account of my observations of the situation including some notable quotations which occurred during interactions. I recorded who, what, when, how I responded and what the outcome was. I described my personal reflections on what I learned, how I learned it, and noted comment on my own and the others' feelings as a process of self learning. Parts of these recordings were relevant for this study. At times I supplemented or filtered these records from memory. The data on Chinese childbearing culture, birthing practices and Chinese migrants experience in the UK constitutes the main body of participant observation data which I present explicitly in Chapter 4 and implicitly in Chapters 3 and 6.

The detailed records of the observations as a midwife, a migrant, a mother and a researcher in Scotland are mainly in English. They are in the form of my diary or data entered in the computer during the course of the study (§2.6). The latter recordings are much more task oriented. The whole process of recording is not only a process of writing down material in black and white upon which to base my final report, but also an opportunity to relate my insights and experiences to theoretical analysis, to reflect from time to time through the stages of my learning and to cross check information gathered with that from other sources.

The records especially those as a barefoot doctor in China, though given the time lag involved in drawing on my memory and the different purposes for which I wrote a diary at the time, have clearly filled gaps not covered by the literature. They look at the ways in which a real person interacted in real situations in her life and reveal general aspects of the rural childbearing life within that country at that period of time. This is not an account of a universal experience but equally, there are many situations, experiences and circumstances described in the study which will strike a

chord. The purpose to present them here is to reflect the study of Chinese childbearing in China and in history from a different perspective.

My various personae between observing and living in society, the professional, the mother, the migrant and the researcher criss-cross to give me rather unique and contradictory perspectives. The disadvantages of being a midwife are firstly, the women tended to look to me for advice and reassurance, secondly, I tended to detach from the women as a midwife, and thirdly, I was prone to making judgements about their perceptions and choices— judgements based on my professional training and understandings. These disadvantages may influence how I see and interpret their experiences. The use of three types of participant observations can provide a more flexible and balanced cross-validation of data. In the case of the observations as a migrant and a Chinese mother in Scotland, my experiences are an aspect of those of the other Chinese women in the study experienced. All these perspectives constitute part of the multiple sets of data to study the childbearing experiences of Chinese and Scottish women having a baby in Scotland.

2.3 The pilot study and lessons learned

After about fifteen months preparation, two tools were developed: a question guide for the semi-structured interviews with the women having babies and a topic guide for the unstructured interviews with other respondents. This study required ethical approval (Appendix VII) from Health Board Committee and permission for access to hospitals from the hospital managers at all levels. In order to recruit pregnant women for the pilot and main studies, an application was made to the Ethics Committee of the Lothian Health Board and to the relevant managers in the different maternity units.

Ethical approval was obtained but the permission to get access to one of the three maternity units was denied because the managers there demanded that the same questions be asked to all the women and that each interview should not be longer than 15 minutes. As the sample size was small and I was able to interview most of the women I needed from the other two units, I opted to recruit further Chinese women through personal networks in the women's homes. This Unit's comments resulted in my making a small number of modifications to the interview questions and shortening all the interviews in hospital to between 30-60 minutes.

The pilot study was carried out on four women at four different stages of their childbearing. Three of them were Scottish and one was Chinese. They presented me with a sharp contrast of the different emphases on diet, analgesia, coping mechanisms, levels of understanding of pregnancy, childbirth and illness during childbearing. For example, both Scottish and Chinese women endeavoured to follow a well-balanced diet. However for the former the notions of what this meant drew on knowledge about the modern nutritional value of different foods while for the latter it drew on knowledge about the 'hot' or 'cold' properties of different foods. Some differences within the Scottish group were also noted even at this stage in their attitude towards medical staff and obstetric technology, and their choices of pain relief.

The pilot interviews highlighted some contrasts both between and within these two groups of people and also revealed some problems. They reminded me of the possible diversity of their beliefs and practices I had to face with the different origins of the Chinese in the UK. The pilot transcriptions also indicated that one hour of interview tape in English required seven hours on average to be transcribed, and the tape in Chinese needed eight to nine hours. It helped me to identify some ambiguous questions and gave me a realistic sense of the time and work involved in this study in each interview, transcription and analysis. I had to reduce my sample size of 20 to 10 of each group because of the time constraint.

2.4 The main interviews with the women

The main interviews were four semi-structured in-depth interviews with the selected parturient women in the study twice antenatally and twice postnatally ideally. The last interview took place not later than six months after the childbirth. The discussion of this section is divided into four parts (1) selection of respondents, (2) how the interviews were conducted, (3) what was covered in the interviews and (4) profile of respondents.

2.4.1 Selection of respondents

Ten Chinese and ten Scottish women were selected for these four semi-structured main interviews. The choice of comparable samples was complicated due to the nature of these two different groups of people. The Chinese women recruited were from Hong Kong, Taiwan and mainland China. 'Chinese' here is a convenient term which refers to themselves or their parents were born in these three areas, who still share certain Chinese beliefs, practices and experiences. They were chosen on the

basis of availability. The representativeness of this group could only be checked in relation to data on the occupational category of Chinese migrants. The Scottish women were identified as those whose parents or they themselves were born in Scotland. They were chosen from the antenatal booking list to match the Chinese women — by age, parity and social class — in order to reduce variance.

Fifteen women were recruited from the antenatal booking list, three from personal friends, and two through the snowball technique. They were invited to join the study by phone or in person and then met either at their home, antenatal clinics, postnatal wards or in a place that was felt comfortable for them.

2.4.2 How the interviews were conducted

The interviews were conducted in whatever language the women were comfortable with, to cover more contextual themes and get reflections on their pregnancy and birth. As it happens I am able to speak Mandarin, Cantonese, some of the northern and southern dialects from China and English and able to understand both Chinese and British cultures to some extent. This was a great help for me when I approached these two groups of women.

Ten to thirty minutes was spent on giving an explanation of the research and requesting consent. Each woman in the study received an information sheet (Appendix III). A written consent (Appendix V) was obtained from her. It was explained to her fully in her native language what the research was about and why it was being undertaken. The explanation to the woman included the information as to how her name came to my knowledge. She was assured that no harm would come to her in term of physical, mental, emotional or social injury. She was re-assured about confidentiality and made to feel free to refuse to participate or withdraw at any stage of the study. Strict anonymous measures were taken at all times.

However gaining four repeat interviews for each woman required persistence. With some Chinese women I had to make many appointments before I could see them each time; I had to telephone one Chinese woman seven time postnatally because she had a strong belief in *zuo yuezi* (§4.3.1, §9.1) and did not want to see anyone during that period. Scottish women usually made themselves available once they agreed to meet me. This may suggest the different cultural attitudes to the concept of appointment. It seems to me some Chinese women did not have a clear idea of the concept of appointment.

Each interview lasted approximately a third to three hours. Many women were usually happy to talk much longer than the agreed length of time. The interviews were not strictly controlled, the women interviewed tended to ramble or move away from the areas I designated to areas which interested them. This technique could reveal some useful information about their concerns. Any missing points were usually noted down and covered in the subsequent interviews. All interviews were transcribed as each interview contributed to the whole picture of its development. Then the transcriptions were amalgamated to make a new hierarchical filing system by bringing all themes together to facilitate analysis and comparison.

2.4.3 What was covered in the interviews

The first interview (Appendix VI) was an introduction to form a rapport with the woman. The aims were to obtain consent, get some general basic background information about family life, health, and the pregnancy. The questions asked in this interview were mostly general and contextual. They were asked about age, parity, occupation (both the women's and their partner's), number of children, religions, length of their stay in Scotland, number of members in the household, some of their experience of childbearing, food, medicine and cultural influence. A home visit or visits were made, if possible. The women were reassured that there was no right or wrong answer but what mattered was their feelings.

The second interview took place close to childbirth in the antenatal clinic/ward or the women's home. The aim was to find out what they knew, how they felt about various aspects of the antenatal care, birthing plan and childbirth. As the pregnancy was advancing and she was approaching her labour, the women were asked the questions about pregnancy, preparation and some forward looking questions as well.

The third interview was done ideally within 5-6 days postnatally, when the immediate euphoria or exhaustion of the birth and the day 2 or day 3's 'baby blues' should have worn off, but when the women's memory of labour was still fresh. The interview took place either in the postnatal ward or at home in the cases of early discharge. It focused on what happened at each stage of labour and how the woman felt about her labour, and how it was managed by midwives and obstetricians, including any technology used

The last interview took place between 1-6 months post childbirth. When possible, it was done earlier rather than later while the women's memory of their

learning process of mothering was fresh. The questions in this interview focused on postnatal care and the issues of rest, diet, cleansing, mobility, activities plus any general reflection on childbearing, childbirth and childrearing.

2.4.4 Profile of respondents

In order to facilitate the analysis and discussion Table 1 and 2 show the background of those key participants in this study. The first twelve are Chinese (W1-12), and the rest are Scottish women (Wa-k).

Table 1 Chinese women

Code	Education	Current Occup.	Pre-preg occupation	Partner's occupation.	Age	Child	Preg-ancy	Baby
*W1	Mid-school	Housewife	Student	Food retailer	26	1st	1st	Girl
*W2	College	Housewife	Civil servant	PhD student	25	1st	1st	Boy
W3	Postgrad	Business woman	Business woman	Business man (Scot)	30	1st	1st	Girl
W4	PhD	Student	Civil servant	Research fellow	30	1st	3rd	Girl
W5	Postgrad	DHSS employee	Lecturer	Draughtsman (Scot)	30	1st	2nd	Boy
W6	College	Housewife	Teacher	PhD student	25	1st	1st	Boy
W7	Primary	Housewife	Kitchen assistant	Food retailer	30	2nd	3rd	Girl
W8	College	Housewife	Teacher	Research fellow	37	2nd	5th	Girl
W9	Postgrad	Engineer	Engineer	PhD student	32	1st	1st	Girl
W10	College	Housewife	Journalist	Lecturer (Eng)	41	3rd	4th	Girl
W11	PhD	computer scientist	PhD student	Medi-physic	39	1st	2nd	Girl
W12	PhD	Student	Researcher	Lecturer (Eng)	42	1st	1st	Boy

NB: * indicates the woman changed her mind and withdrew from the study.

Twelve Chinese women were contacted but only ten of them recruited into the comparison group. Two Chinese women changed their mind and withdrew from the study at different stages. One woman became fearful and suspicious of the outcome of the study because she was a new migrant. The other withdrew because her husband disagreed with her participation. After each withdrawal I had to think through the circumstances and the approach employed — for example, whether I dressed appropriately for the occasion, whether the time and place of the visit well inappropriate, and how I introduced or explained the study to identify the causes. After each withdrawal, I selected another woman with the same or similar background as a replacement.

The remaining ten, six were from Mainland China, three from Taiwan and one from Hong Kong. Their age range was 25 to 41. Seven of them were having their first baby and three of them the second one.

All Chinese women had completed at least undergraduate education apart from the one from Hong Kong. The women from mainland China knew little about or did not want to know about, traditional customs and beliefs on health and childbearing. They regarded these as feudal and superstitions, but they had a strong desire to maintain their cultural identity. The women from Taiwan were inclined to draw on non-medical resources if they felt the need. The woman from Hong Kong, who was working class, had some knowledge of Chinese traditional customs and beliefs on childbearing but she did not follow them. No matter where these women originally came from, their present social context had exerted some influence on their thinking and behaviour even though many of them were still trying to cling to their original beliefs and ideology.

There are three distinguishing features of the Chinese women recruited for this study. First, the student population is disproportionately high compared to the migrant population in the UK. This may be due to the location of the main maternity hospital, which is in the centre of an international city with four universities. Secondly, there are more women from mainland China than from Hong Kong and Taiwan while the Chinese population in the UK is predominantly from Hong Kong and Taiwan (Li 1992: 105-6). Thirdly, the Chinese mothers in the study happen to be better educated than the average first generation Chinese migrants in the UK.

Table 2. Scottish women

Code	Education	Occup.	Pres. occup.	Partner's occup.	Age	Child	Preg na	Baby
Wa	College	Health worker	Health worker	Doctor	32	1st	1st	Girl
Wb	College	Housewife	Staff nurse	Electro-engineer	27	1st	1st	Boy
Wc1	Postgrad	Researcher	Researcher	Civil servant	37	1st	1st	Boy
Wc2*	Postgrad	Unemployed	Researcher	Civil servant	39	2nd	2nd	Girl
Wd	High school	Housewife	Catering worker	Food retailer (Chinese)	25	2nd	2nd	Girl
We	PhD	Student	P/T teacher	PhD student	34	1st	1st	Boy
Wf	College	Housewife	Unemployed	Builder	32	1st	2nd	Boy
Wg	College	Child minder	Child minder	Engineer	32	1st	3rd	Girl
Wh	College	Worker	Worker	Electrician	33	1st	1st	Boy
Wj	Postgrad	Retail manager	Retail manager	Retail manager	39	1st	1st	Girl
Wk	College	Housewife	Catering retailer	Catering retailer (Turk)	42	1st	1st	2 boys

* Wc2 refers to the same Scottish woman Wc1, who gave birth to her second child.

Ten Scottish women were contacted and recruited to the comparison group. No one refused to join the study. They were chosen to ensure comparability with

those recruited Chinese women — by age, parity and occupation. One of the women turned out to be Irish though of Scottish descent. The criteria of age, parity and occupation were expanded into age range, number of childbirth and occupation grouping because of the difficulty of obtaining exact matching in a limited two years period. The Scottish women were also chosen to reflect the unusual disproportion of students in the Chinese group.

Generally speaking the Chinese mothers required more explanation and reassurance to enable them to participate in this study than the Scottish mothers who appeared relatively more ready to accept the invitation, a little more self centred but frank to talk about how they felt, and to answer all questions. It gave me the impression that Scottish women had a strong sense of being the 'master' of one's own affair, while the Chinese appeared to have more hesitation. I always tried to judge the best way to react to women in order to gain their co-operation.

In comparison Chinese and Scottish women differed in general in matters of individuality, the notion of autonomy, privacy, ideas of self-development and the need for an expression of individual uniqueness. As far as these were concerned, the childbearing experiences of Scottish women appeared relatively more unanimous to some extent in contrast to their Chinese counterparts. Equally one may argue that, in comparison, the Chinese in Scotland are more diversified socially and culturally.

2.5 The 'other' interviews

The other interviews consisted of unstructured talks and/ or discussions with five relatives, 10 mothers, 10 friends, 10 health workers and three group discussions with 3-6 informants, as there is no rigid rule regarding the total number of subjects in a qualitative design.

2.5.1 Relatives and friends

Relatives and friends were invited to talk freely and make free associations about their experience of childbirth and how they saw the women's experience of birth and the roles they could play. In addition to five relatives, five Chinese women friends and five Scottish women friends were consulted informally. Two group discussions were conducted on Chinese diet during childbearing, with three and six Chinese friends respectively, and one group discussion, on Scottish postnatal diet and mobility with four Scottish mothers and a health worker. They were recruited on a voluntary and convenient basis.

The informal talks with friends and two group discussions with Chinese friends were not taped in order to avoid unnecessary misunderstanding but detailed notes were taken retrospectively. The Scottish group discussion was taped and transcribed. An attempt was made to transcribe the data fully and accurately but this was easier said than done as the tape was not always clear, or the respondents spoke too quickly in broad dialect, or sometimes, several speakers spoke at the same time.

2.5.2 Health workers

Ten health workers at different levels or posts were interviewed informally to hear their views on the experience and needs of Chinese and Scottish women in relation to pregnancy and childbirth and how they saw pregnancy, birth and birth management. They are:

P1—obstetric consultant

P2—obstetrician

P3—pharmacist

Pa—midwifery manager

Pb—dietician

Pc—junior midwife

Pd—midwifery educator

Pe—senior midwife

Pf—junior midwife

Pg—health visitor

Most of the interviews with the professionals were taped if they agreed and transcribed separately, then categorised, compared, analysed and summarised.

2.6 Data analysis

The thesis provides systematically both a thematic and chronological analysis of social, historical, medical contexts of childbearing for participating Chinese and Scottish women having babies in Scotland. The concern of this section is to present the method of analysis that have been used but not been discussed in depth in the chapters. This is divided into two sections: frame work for analysis and detailed data analysis.

2.6.1 Framework for analysis

The concept of Childbearing (§1.2) is used to include women's experiences of pregnancy, birth, postnatal recovery plus wider social, cultural and medical contexts and the meanings associated with having babies. The interpretation of childbearing experience of Chinese and Scottish women with distinct cultures and histories demands an anthropological approach because these actors, have to be understood with reference to the particular milieu in which their everyday lives are organised. Accordingly the study has used a selection of the materials, conceptions and methods from more than midwifery and sociological disciplines. It combines history reflection on childbearing and anthropological contemporary fieldwork approaches to analyse and explore human diversities not simply as an isolated biological creature, a bundle of reflexes or a set of senses and instincts.

The overarching theme running through this study as a whole is the social and cultural construction of childbearing (§1.2). The social and cultural construction of childbearing requires sociological analysis of the wider context of gender, medicine and health seeking behaviour, status and experience of the women in the study. Relevant sociological aspects of childbearing include the power structure of a social state, issues of women's choice and control over childbearing, and anthropological elements, such as the rite of passage of childbearing. The historical and anthropological work of this study is not only confined to social and historical explanations of the behaviours of Chinese and Scottish women but also more importantly to an understanding of the contemporary sociological changing and transitional features of childbearing of these two groups of people in the Scottish medical culture.

2.6.2 Detailed data analysis

Data analysis involved keeping a file which included notes, bibliographical items, the outlines of the project and field diaries in order to combine what I was doing and what I was experiencing personally. File keeping encouraged me to capture various ideas and to develop self-reflective habits and the habit of writing. The notes taken down sometimes led to more systematic thinking.

The four or more interviews conducted with each mother in the both groups were recorded and transcribed. Each woman was regarded as a case and filed under a reference code. A reflective summary of each individual and each interview was made, highlighting important individual concerns and issues. This case file allowed me to

read the interview as a whole and facilitated me to see the development, changes and context of events. However this approach inhibited ready comparison across a number of cases between related responses.

The case files were amalgamated to make a new hierarchical file system in order to bring all the relevant themes together and compensate for the disadvantages of the case file mentioned above. Each topic within a similar theme was filed as a document in the same file. The next step was to select significant topics and group sets of responses to each topic into relevant categories, then documents. This information was used as a reference point to identify different important issues emerging from the interviews with Chinese and Scottish women.

This method had advantages and disadvantages. It facilitated comparison and analysis by sorting and indexing, but it made it difficult to see the interview as a whole or in context. The hierarchical amalgamation of case files facilitated the analysis and put the data into perspective. The rearranging of files was time consuming but it did also encourage systematic thinking.

On a practical level the process of the analysis consisted of transcribing, reading, coding, annotating data, finding focus, listing, sorting, categorising, redefining categorisation, making connections, linking, retrieving and associating data. These processes of organising and associating relevant points and problems via a computer could put the data into perspectives, easy accessible and meaningful interpretation. Reading was the most important and fundamental process of interpreting and analysing the data to find out who, what, when, where, how and why—in other words to view events, action, norms, values, etc. from the perspectives of those being studied. Very often I discovered myself reading the transcription more than ten times in order to internalise the mental state of the women and to note the inference and implication of the mothers.

The transcriptions and interpretation of data were influenced by its material, content and context. The data were analysed horizontally, by two techniques: (1) textual and content analysis, and (2) contextual analysis. The meanings were interpreted vertically at two different levels: (a) surface meaning, and (b) underlying or deep meaning (inference and implication) in relation to context. As I went along and the data became richer, I had to shuttle between theories and empirical material, guided by the desire not to lose intended meanings and yet to be quite specific about them.

This was helped by inviting my supervisors to read some of my transcriptions and manuscripts and hear their comments.

2.6.3 Textual and content analysis

Textual or content analysis is

an honest effort ... to make indicative research more scientific, rigorous, and scholarly—in other words easier to control (Stern 1989: 152-3).

The analysis of the content of the transcription helped to develop a rationale, to set up and clarify a set of categories (Wilson 1985: 408) which could put data into meaningful perspectives.

The analysis of material involves paying close attention to words that are used, especially their degree of generality and their logical relations. The purpose of the material analysis is to be aware of the assumptions and implications of whatever they are.

Everyday common sense is filled with assumptions and stereotypes current in a particular society. In many ways common sense is useful in a designated culture as it determines what is seen and how it is to be explained. In other words many people use their common sense without too much questioning. Their common sense may not be so effective when they are dealing with the people outside their own community. Different common sense in different positions may offer a different interpretation about the same subject as 'the facts'. The different 'facts' may be changing as the different people changed. The information about the same subject may be contradictory. They are just different opinions from different perspectives for comparative analysis.

This can be observed in the analysis of the term 'Chinky' (§6.4), meanings of 'hot' and 'cold' (§3.2) and the phrases of 'zuo yuezi' (§4.3.1 and §9.1). They have different sociocultural meanings. The distinction of the function of these expressions is useful in analysing the social interaction between people. For example, the syntactic analysis of *zuo yuezi* brought light to me and enabled me to see the misunderstanding of the previous researches, and directed my attention to its clinical socio-cultural implication (§4.3.1). Similarly the analysis of the concepts of 'normal' and 'natural' birth (§1.2, §5.3) indicated their instrumental role in terms of their relationships with the women, health workers and obstetric technology. Different people have different understanding and different interpretations. A better understanding of the women's

ideologies, fantasies and weapons for gaining control in labour was obtained through careful comparison and analysis of all relevant texts available and the transcriptions.

2.6.4 Contextual analysis

The context of the women's experience of childbearing provides cues for understanding and interpreting the meanings of childbearing. Knowledge of the women, topic, theme, setting, channel, code, event, purpose etc. in a given communication situation makes it possible for the reader to have different expectations, such as what is likely to be said in a compatible manner expected. The foreknowledge of Chinese and Scottish women's perception of and attitude towards their health, illness and childbearing would help the health workers to understand their clients and bring them into the scene faster to construct their own perception, expectation and interpretation by sharing a number of contextual assumptions.

2.7 Reflexivity

This section is to link explicitly with the views as insider and outsider discussed in §2.2 and some problems confronted in the study in association with the dual value of insider's and outsider's viewpoints. It consists of three parts: insider and outsider, sceptical subjectivity and language.

2.7.1 Insider and outsider

I experienced suspicion of me being an outsider in both settings. Some doubts of some Scottish people about my ability as a researcher initially because it was thought impossible to compare Chinese and Scottish women, if I did not intend to ask them the same questions. A few Chinese participants made some suggestions of agency role by asking if I was sent by the maternity hospital in Edinburgh. I had to discount my fears of possible rejection based on their doubts expressed. The announcement of being a researcher from the start was helpful for me in gaining entry in the field. Being a Chinese new mother myself during the period of interviews, Chinese women I interviewed soon stopped seeing me as a researcher and reacted to me as one of them who could understand and share their feelings. The Scottish women perceived me as a Chinese professional who was eager to learn about them and who had little access to the network of their family and friends and therefore posed no threat of spreading gossip.

The disadvantage of being a midwife was that some of the participating mothers — Scottish and Chinese — responded in a way that they thought I expected, and tried to socialise me into a helping role providing them with assurance and advice as a midwife. To handle this situation I had to separate myself from the role of a midwife and refer them to appropriate professionals in a non-emergency situation. It was made clear to the women that any problem they had could not be dealt with by me. Great care was taken not to interfere in the professional-client relationship. Fortunately I did not have to play any immediate emergency role as a midwife.

Doing field work as a midwife and a Chinese mother offered me a way to immerse myself in both cultures under study. Participant observation enabled me to be part of the culture and the women's life under observations, and to become sensitive to problems of meaning and context through a process of interpreting and sharing the experience of the women. My presence in the field and the interviews often triggered the women's self-interpretation as well. In the whole process of investigation, the researcher's self is used as one of the primary tools for data collection in addition to the tools of the interview guide and questions. In this sense, the study is not only an account of what I have seen and perceived but also an explicit analysis of my 'intangible inner experience' (Okely 1992: 16), revealing conflicts as a midwife, observer and an individual both in China and Scotland through embodied activities and practices. For example, I am a midwife, emotionally I am a researcher but I am also and always an individual with my own personal physical and emotional needs. Participant observation requires me to persuade myself to suppress my personal needs and my feelings in the interest of the study. My emotional marginality conflicts with my individual needs and has to be dealt with in the process of my analysis of my data and method.

In the contact with my friends and the informants, the temptation to become involved was always present. I had to fight the urge to react spontaneously to the situation, to relate to people as a person and to derive pleasure rather than data from the situation. Often I had to decide how much spontaneous participation was possible without endangering the neutrality which the researcher must maintain. It was easier when the discussions were not on the topics I was studying; but when they were I had to struggle hard to keep my opinions to myself. My role as the researcher was sustained by this constant struggle. Despite the effort I had made to maintain my detachment, I became involved somewhat as well on a conscious level under pressure from those I studied. For example, apart from not wanting to alienate the people under study, I felt a desire to be part of the group and to be liked in some way. This urge

became even stronger when dwelling on mothers' birthing experience, which sometimes resulted in me give away some of my feelings. However the non-participant observation as a midwife and researcher help me to make sense of the perspectives and activities of the people under investigation.

After the series of in-depth interviews, many of the women interviewed became my friends. I had to choose some small present for them or their babies when I visited them. By the time I had my baby, they gave me and baby a lot of presents too when I visited them. This conflicted with my decision to remain detached from them as a researcher. At the same time, I also had to face a dilemma about where to draw a line between friendship and their informed consent, between the information given in the interviews and information obtained during interactions as a friend.

2.7.2 Sceptical subjectivity

Social reality has an objective and subjective dimension. If it is to be accurately perceived it must be understood subjectively and objectively. Subjective understanding is obtained through using one's reason, sense and intuition. To be objective about social reality, paradoxically it has to be understood the subjective world of meanings, not only that of the observer but more importantly that of the people being observed. Objectivity can only be achieved through accurate subjective interpretations of social reality, which is 'relative to man's definition of it, and man's definition has been notoriously relative to his consensus in particular times, places and social circumstances' (Bruyn 1966: 191).

Objective knowledge is important but it now is no longer seen as absolutely separate from subjective experiences in the field (Hastrup & Hervik 1994: 1). It would be difficult to think of any scientific objective knowledge without any involvement of subjectivity. Complete objectivity is an ideal but can never be fully achieved by social scientists. 'To be more objective about man in society, social science today must become more subjectively adequate' (Bruyn 1966: 163, 219-225).

So the cultural opposites of subjectivity and objectivity have a complementary relationship. Understanding one polarity can contribute insight into understanding the nature of the other. 'Objective entities' (Hastrup & Hervik 1994: 1-2) are thus constructed by the subjective knowledge of an actor, the 'insider' and the objective perspectives of the observer, the 'outsider'. They are to encapsulate the understanding not only of the childbearing culture of Scotland from different dimension but also the processes from the experiences of the self to a valid knowledge of the others by which

this childbearing culture is reproduced and transformed. The experiential connection relates the women under investigation and the researcher.

The three types of participant observation utilised in the study add another dimension of sociological knowledge to provide more meanings to our understanding of childbearing in Scotland. Each type of interpretation contains a picture of social reality which includes values and objects that shared in the consciousness of the women under study and the researcher. As the recording of the analyses of these three types of observation is getting closer to the experiences of the childbearing women in the study, the subjectivity and objectivity increase at the same time.

2.7.3 Language

Language is considered here in its broadest sense as it is used to express meanings and feelings. Three features were identified in the process of transcribing and analysing the interviews with Chinese women:

First, the interviews with Chinese women were all carried out in the Chinese mothers' own native tongue—Mandarin, Cantonese or other dialects. When the interviews were translated into English, most of them were in standard English and the rest had to use either Romanised Chinese terms or literal translations with some attachment of new definitions because it was impossible to translate from Chinese to English terms like *zuo yuezi*, *yin yang* and 'hot' and 'cold'. Similarly my Chinese informants often used English words and expressions in the interviews which they found inappropriate to express in their own language like GP, antenatal classes, birth plan, health visitor, etc. When such terms are put into another language, the reference, inference and implication of the associated customs and practices get lost. The application of these 'loan' words and expressions in both languages is due to cultural and environmental differences. The absence of these cultural conceptualisations of certain cultural logic, social phenomena and social organisations or structures makes these literal translations meaningless. In this situation it requires me to make detailed elaboration and interpretation of the cultural context and meanings. It is in a way a feature of the relationship which I, as the researcher established with my informants. I often had to check the conceptualised meanings from my own point of view with those which actually exist from the viewpoint of the people under study.

Second, the subtleties of regional differences in Chinese languages and dialects are difficult for an English speaker to contextualise in English unless he or she has a past history of close contacts with Chinese people from different parts of China.

The followings are two quotes from two women to illustrate some subtleties and difficulties a non-Chinese speaker may face.

Guiyuan (dried longan pulp) is good for *buqi* (complement life force) (W9).

The *bu* food for *zuo yuezi* are *guiyuan* and brown sugar...(W 10).

Though both of the mothers mentioned *guiyuan* for *bu* food, the way they presented it and the association of the perception of *bu* with the other food gave hints roughly to each woman's origin and their different levels of the knowledge of Chinese medicine. The word *guiyuan* gives a cue that these two women were from the southern part of China but different areas because the first one did not mention brown sugar, and *guiyuan* and brown sugar are always cooked together in the area around Shanghai. The use of *buqi* in (W9) suggests that the woman was more familiar with Chinese medicine to support and justify her statement that *guiyuan* is good for a woman's postnatal diet. Such markers of origin, styles and individuality get lost to some degree when they are put into another language and read by a non-Chinese speaker. These subtleties of the language and regional variations were retained for analysis mainly because of the researcher's bilingual and bicultural understanding.

Third, no Chinese mothers were comfortable being interviewed in English, no matter how fluent their English was. Talking in Chinese also offered them an opportunity to engage in chitchat that not many Scottish people can appreciate. To be able to speak their own languages this was as if it granted me a membership in their group and brought me closer to them. Not surprisingly using the mother tongue enables people to express their thoughts and culture more readily and promptly, and also convey subtleties and local flavour. The ability to speak the same language and to share the culture of the Chinese women under study can facilitate the recordings more closely to the original statements, as they were uttered in their world of experience. This aspect of conveying their thought and feeling postulates their natural process of changes and adjustments in Scotland. The closer my data come to their reality, the less important are the distinctions between subjective and objective knowledge, which are discussed in §2.7.2.

2.8 Summary

In the preceding pages, I have tried to describe some of the methodological considerations involved in the collection, observation and analysis of the data of childbearing experiences of Chinese and Scottish women in Scotland. The study was

primarily an interview-based study, which is conducted, analysed and supplemented with literature reviews and participant observation. Participant observation was used as a secondary tool which provided the initial impetus and motivation for my study. It was utilised as a filter through which I interpreted and made sense of the material from the literature and interviews. It also obliged me to address the conflicting perspectives and concerns that I had as a 'immersed' actor and as a 'trying to be detached' researcher. In this spirit, I tried to bring a sceptical subjectivity to the study.

Together, these methods helped me to explore and contextualise the spectrum of different meanings and practices of childbearing, including the intra-family relationship of the participating women and their inter-relationship with the health workers. The application of these methods is a trade off between depth and breadth. It enabled me to go beyond what people told me about their cultural beliefs and practices to what they actually did. This is especially evident that my study demonstrated how Chinese women followed their traditional postnatal customs in Scotland. The detailed analysis of the main empirical data collected from semi-structured and unstructured interviews are presented in Chapters 7, 8 and 9.

Chapter 3

Chinese social and medical context

All the Chinese women in the study came to Britain as adults from three politically and economically different Chinese societies: Mainland China, Taiwan and Hong Kong, and were all born in 1950s and 1960s. They brought with them Chinese social and cultural expectations and still shared certain beliefs, practices and experiences, by which I identify their 'Chineseness'. Consequently, their birthing experiences in Scotland, although quite different from those in Chinese societies, have to be considered in relation to Chinese society and culture in general. This chapter reviews literature outlining the social position of Chinese women, the Chinese medicine and health care systems in these three areas and, drawing these two threads together, the position of women as patients in China. This examination will provide a foundation for subsequent discussion of the childbearing experience of Chinese women in Scotland.

The differences among the people from these three areas are that Taiwan has more educated, upper, middle class people, who were evacuated from mainland China in 1949 after the defeat of the National government. Apart from their political ideology, According to Wolf (1972: 13), the sinologist, Taiwan 'women's lives are much the same all over China'. Hong Kong is a former British colony. It is more international and consists of more working class people. In addition to traditional Chinese customs and culture, Hong Kong people have a variety of choices in their own standards, and notions of knowledge which reflect their political and economic systems and their close colonial tie with British medical culture (Topley 1978a: 111-2). The practices of Western and Chinese medicine coexist in Taiwan, Hong Kong and mainland China (Gallin 1978: 175). In general women's choices and decisions in their family building are influenced by their conceptions and evaluations of their political and economic systems.

The Chinese women in Scotland showed individual differences associated with their social environment and their degree of 'Westernisation' in a similar way to the Asian women's experiences of childbirth in London suggested in Woollett and Dosanjh-Matwala's study (1990a: 19). But undoubtedly, some Chinese social and cultural expectations have survived and formed the basis of social and cultural

backgrounds for the Chinese women in Scotland. Therefore the assumptions, attitudes and experiences of Chinese women from those three areas were used as the main reference points for my study. This is helpful in order to understand why Chinese women in Scotland presented themselves with patterns of behaviour in their childbearing, how they coped and managed to integrate traditional Chinese birthing practices and beliefs into a new cultural and social environment (Ch 6). The variation in their responses and the ways in which the Chinese women in my study were also similar to Scottish women, are discussed in chapters 7, 8 and 9.

3.1 The social position of women in China

The social position of Chinese women from mainland China, Taiwan and Hong Kong has been documented respectively by some sociologists, anthropologists and sinologists in Britain (Croll 1978, 1985a, 1995, Hall 1997) and in America (Sangren 1983, Ayscough 1938, Davin 1976, Wolf 1972, 1975, Wolf 1978a, b, Ahern 1978a, b, c); and by some Chinese scholars (Lee 1994; Li 1992; Liu 1976; Hu 1992: 3-15, Yang 1992, Sung 1992). Some of them have conducted fieldwork among Chinese women in these three areas since 1949. The interest of West European scholars in Chinese women is directly related to the feminist movement in the West and gender issues in social sciences scholarship. Their studies have also generated interesting and stimulating data and have provided insights on the problems of gender equality in China even for Chinese natives. Some anthropological studies have undoubtedly presented some insiders' views of women in China (especially Croll 1995). An insider's view, of course, represents an individual's experience, and it should also be read in particular political contexts as discussed below.

In this section, I first discuss the social status of Chinese women in general from a historical perspective and then go on to discuss Chinese women's social position according to the roles they have played in Chinese society: as workers, daughters, wives, daughters-in-law and mothers, which may vary from Chinese society to Scottish society (Cf. §5.1 in which the position of women in Scottish society is discussed).

3.1.1 Chinese women in society in general

It has been observed that before the middle of the twentieth century, the status of women in mainland China (Jacka 1997, Hall 1997: 177, Croll 1995, ACWF 1989, Stacey 1983), Taiwan (Li 1992a & b) and Hong Kong (Wolf 1972, Salaff

1981, 1995) was lower than in most societies in the world. In ancient China, although poor women, especially in the southern part of China often had to work outside the home, women's social sphere was ideally within the home while men's social sphere was outside (Chen 1727: 336). It was the social role of women to do housework, to give birth to and bring up children, and to support husbands from home (ACWF 1989: 3-4, Wolf 1972). If no children were born, the women were blamed and could be dismissed by their husband because of this.

They were traditionally expected to follow 'three obediences' (*Sancong*) or 'three dependencies' prescribed in the doctrines of ancient Chinese literati represented by the literary and cultural figure Confucius: obedience to father before marriage, to husband after marriage, and to son after the death of husband (Cheng 1948: 34; Ayscough 1938: 63; Wolf 1972, Stacey 1983: 39). The logic for the dependencies was that before daughters got married, their father had to support them; after their marriage their husband had to do that; and in their widowhood, their son had to bear the responsibility. 'Three obediences' summarised women's submissive roles in the family hierarchy, and the 'three dependencies' of women made clear the responsibilities and duties as the father of a daughter, the husband of a wife, and the son of a widowed mother. For more than two thousand years these triple obediences were the basic social values for all Chinese women everywhere to observe and placed them under male control from the cradle to the grave. These *Sancong* emphasise the role of woman as daughter, wife and mother, and impose spiritual fetters on women dictating their social status, fulfilment and economic dependency on men in Chinese society (Tsai 1986: 157-8).

Most Chinese women in my experience today still acknowledge covertly their submissive roles and dependency especially on their fathers when they were young or before marriage, and to some degree, on their husband after marriage, and on their sons in their old age. But they also see that there is now some mutual responsibility and dependency within the family, between themselves and their husbands, and between themselves and their sons and daughters.

The lives of Chinese women underwent significant changes because of the influences of two other cultures (Ch'en 1992: 59-71); one was from India through Buddhism in the third to thirteenth centuries AD and another was from Europe and America in the beginning of the twentieth century. These two cultures changed Chinese culture to some degree, for instance, freedom to choose one's partner, the right to inherit property and money, and family planning. Such influences have

brought in new ideas for the Chinese culture to absorb but have also threatened the structure of the traditional Chinese family. Traditionally, a Chinese family is perceived as much more important than the individual. The love between a husband and a wife is not denied but it is subordinated considerably to their duties as a son, as a brother, as an uncle for a man; and a daughter, a daughter-in-law and an aunt for a woman.

The educated influential Chinese began to advocate equality between men and women in the late nineteenth century after the Opium Wars, when they initiated political reforms. That was the beginning of the women's liberation movement in China, which echoed that in the West. A women's liberation movement started alongside the Chinese revolutions that arose at the beginning of the twentieth century (ACWF 1989). At the same time, the Chinese learned circle questioned the common perception of the inferiority of Chinese women. Hu Shi (Shih) (1992: 3-15), the intellectual leader of modern China pointed out in 1931 that Chinese women had been able to make valuable contributions in traditional society within the family, in literary circles, in education and to a limited extent, in government. Many other writers (Li 1992, Lee 1994: 1, Yang 1992: 16-33) also re-evaluated the position of Chinese women in pre- and post revolutionary China along these lines.

Some writers have found that Chinese women on the whole presented a contradictory picture both domestically and socially (Lee 1994: 1). On the one hand the traditional customs try to keep women weak and incompetent at academic achievements (Li 1992: 103-7); on the other hand a few elite women have become outstanding and well respected in their respective fields or at home mainly in the twentieth century. The famous women cited in these cases were talented, highly committed women or they were usually born into better off families. They had a better opportunity for scholarly, political or military achievement (Lee 1994: 1). The history of the vast majority of ordinary women is not as well documented and therefore their position in society is more difficult to evaluate. In my view, the successful women before and after the 1949 Communist revolution of all three areas are only small in number and quite exceptional in their backgrounds. Their cases are not typical of Chinese women as a whole. This evidence therefore does not undermine the conclusion that the majority of Chinese women were perceived as inferior before. The argument made by modern scholars is clearly part of an evolutionary change in the perception of the rights of women.

The women in mainland China, alike the women in Taiwan and Hong Kong, were recognised as legal individuals after 1949 (Croll 1995: 69-72). They were no

longer merely daughters, wives, daughters-in-law or mothers, they were also workers in their society, according to the new social expectation. The state ideology is that women are equal to men and they can 'hold up half the sky'. Now, they are looked upon as independent members of the community, who have not only the capacity, but also the right, to develop and use their talents. Although there is still no absolute equality between men and women in practice, life has offered women far more freedom and opportunity than before (Croll 1995: 176, Hall 1997: 10-11, 93-4).

Chinese women have been encouraged to engage in financially gainful work at home, in farm work, trade, business or other employment since 1911. The low pay both in urban and rural areas has driven most women out of the kitchen to participate in gainful employment outside the domestic sphere. Work outside the home with the industrialisation and modernisation in Hong Kong, Taiwan and urban areas in mainland China has not only granted women new identities as social individuals but also brought them an opportunity to enlarge their public social contacts (Croll 1995: 69-85, 176-179, Salaff 1981, 1995).

It was also observed in mainland China that the emancipation of women from domestic life to public working life during and after the Chinese revolution meant women becoming 'androgynous' (Croll 1995). Their roles in society were redefined in terms of their male peers. Politically, Chinese women had been liberated from the domestic sphere. In reality Chinese women had to work harder than before and take a double workload inside and outside of their home (Davin 1976: 123, Kang 1988: 410). The problem of women being 'androgynous' was once noted in Chinese policies in gender equality (Croll 1985b: 34, 1995). The Chinese liberation of women has sometimes missed the point of sex and gender equality. Clearly, the problems of gender equality were not taken seriously in the early period of the Chinese Communist revolution, though it advocated the liberation of women. Thus the equality bestowed upon Chinese women by the revolution has been perceived by many of them as a rhetoric which is far away from the day-to-day reality for women. In other words, Chinese women since the liberation have not gained real equality with men in society. Women are still seen as holding unfavourable positions in the society in comparison to men (Croll 1995: 119- 132). Discrimination against women is noticeable in both urban and rural settings throughout mainland China. The prevailing attitudes towards and treatment of female infants show preferences for the male and provide strong evidence of sex inequality in mainland China (Croll 1995: 1, 111, 164).

Croll's study (1995) on Chinese women has combined historical, textual and

contemporary fieldwork approaches. To some extent the study has presented some in-depth observations of Chinese women in mainland China. From my personal experiences before coming to Scotland, the real problems of sex and gender equality in modern Chinese society have yet to be pinpointed, which should take into account the cultural diversity across the country and the cultural uncertainty in the revolutionary and industrialisation era of China. One can argue that the Chinese revolution and modernisation have been unable to provide sufficient redefinition of Chinese cultures which have been changed drastically in the revolution (cf. Hall 1997: 178). Therefore, the revolution, including women's liberation, has been experienced by many as a delusion. It should be noted that in Croll's study (1995), the problems of gender inequality have been presented across at least three to four different historical stages in Chinese political culture: imperial China, the Republic revolution that overthrew the emperor in 1911, the Communist revolution, including the Cultural Revolution and the Reform for a more open Chinese society starting in the 1980s. There is evidence to suggest that Chinese women's social position has been improved since the Communist revolution (Croll 1985a: 33, 44, 69; Hall 1997: 1, 177). Men and women were normally equally paid in state employment. The percentage of women in state employment was about 20 percent of the population at that time. There is also evidence to suggest that in the Reform period since the 1980s, the old ideas about women's roles and positions in society are being revived (Hall 1997: 15, 178). The revival of old Chinese ideas about the differences between men and women are largely responsible for the discrimination against women that occurred in the 1980s and 1990s and are observed in the recent studies (Croll 1995: 110, 120, 164; Hall 1997: 111).

A similar picture could be found about women in Rural Taiwan, whose wages were low but 'A worthless girl is no longer quite as worthless as she once was' (Wolf 1972: 99). It is also the situation in Hong Kong (Salaff 1981, 1995).

The social roles of Chinese women can be divided into daughter, wife, daughter-in-law, mother and worker. The decision-making power of their roles is different between households from different regions, social classes or ethnic groups. Their social position in terms of various roles they play is discussed below.

3.1.2 Women as workers

Most Chinese women workers nowadays engage in agricultural work and light industries, including domestic services. The old perception of the inferiority of women was changed among the educated Chinese in the twentieth century, followed

by the change in their social position, from housewives to workers. The involvement of the concept of women's occupation or social position here does not mean that it causes differences in childbearing but rather points to some other factors such as life styles influenced by social and economic characteristics, customs, practices and values, which might lead to poor nutrition, stunting of physical growth, poor hygiene, prevalence of infectious disease.

In the southern part of China, rural Chinese women had been playing crucial roles in agriculture (Croll 1995: 124-132) and participated in domestic handicraft industries like embroidery, spinning and weaving prior to and after 1949. They had full responsibility for weeding, transplanting, harvesting the crops with men, tending livestock, laundering, making and preparing clothing and shoes, preparing meals, and rearing children (Stacey 1983: 23). In the northern part of China they participated in agricultural work primarily during the peak period of labour demand and concentrated on domestic and handicraft work. In general most domestic tasks were the responsibility of women in the countryside. The peasant household is now the dominant unit of production since 1980s. The woman's independence, individual rewards and bargaining power within and outside the household are dependent on their relation to the male household head, and the woman's role is still secondary to men within the Chinese family system. There are more traces of the rules of 'three obediences' in rural areas than in towns and cities.

The literature available suggests that Chinese women in Hong Kong (Salaff 1981, 1995), in urban China (Croll 1995) and in Taiwan (Wolf 1972) feel that they play a role in family decision-making. They would deny the 'three obediences' but at the same time they seem to follow some rules and place great importance on the moral side of the rules. Women in industry are predominantly employed in food-processing, catering, hotel, retailing, textile and light industries and perform less mechanised, less competitive and lower-paid jobs. The unemployment rate of women has been higher than that of their male counter-parts in the work force because they are thought to be more expensive because of the cost of providing maternity leave, child care, nurseries and other services. Pregnancy, childbirth and breast feeding in mainland China (Croll 1995: 121) were estimated in a survey to cost a business more than 1259 yuan (roughly about £100) per worker a year. Chinese women in these three areas nowadays are no longer living a secluded life. In urban areas they are trained as nurses, doctors, skilled workers, preparing for the teaching profession, and studying sciences. In rural areas women receive compulsory primary and secondary education and at the same time help their parents to perform domestic and farming work of every

kind. Some of them may migrate into urban areas in their adulthood to find a job to diversify their operations and expand their range of off-farm activities. Many girls begin their urban careers as domestic servants for richer people and then go on to find employment in more lucrative retail and service outlets (Croll 1995: 130). They seek economic independence and can also help their family in the countryside. Some of them marry in the towns and leave the countryside for good and some return to their village to marry.

The position of Chinese women in society has changed politically in the twentieth century in the Chinese revolutions and in the influence of modern European cultures. The socialist feminist movement started in the West had pushed that change further in post-1949 China. The change had taken place so far as a state political ideology in that women should be equal to men in all aspects of social life. This, however, was not what had happened, as other studies have already shown that the liberation of women in post-1949 China is to some extent a political rhetoric, an illusion to most women in mainland China. It is also observed that there has been a tendency in the Chinese revolution to liberate women as 'labourers' (Croll 1995). Urban Chinese women in particular have become more independent politically and economically and more Chinese women have entered public life, but their employment is mainly in light industries and in less competitive and low-paid jobs. This can be seen as an extension of the domestic sphere of gender division of labour which underlines the gender relationship in traditional Chinese culture (Jacka 1997: 4).

As China has gone through a series of changes since the beginning of the twentieth century, especially after 1949 and the Cultural Revolution in the 1960s and 1970s, Chinese women have been encouraged to work for the common good and collective welfare and the need of the State (Sung 1992: 87-101). The new expectations called for adjustments in the roles of women. Women form 38 percent of China's labour force in the 1990s in mainland China (Croll 1995: 117-119, Hall 1997:47). The status of women in Taiwan (Li 1992a & b) and Hong Kong (Salaff 1981, 1995, Wolf 1972) is similar in general to the status of women in mainland China but has their own geographic and economic features. Their status there is more economically defined rather than that is socially and politically led in the case of mainland China. In the process, the old Confucian ideal of women's self-denial for the sake of the family has been transformed into a new ideal of self-respect, self confidence, self-reliance and self-improvement (Croll 1995: 150). Selfless dedication to the State is a main present-day theme for Chinese women in the modernisation of their country. It promotes the concept of fulfilling one's duties but not so much the

particular duties as daughter, wife and daughter-in-law.

3.1.3 Women as daughters

Life on the whole is harder for girls than for boys in all three areas. The family system of traditional China restricted and oppressed women of all classes. The most impressive resistance to 'tradition' is non marrying sisterhoods¹ (Wolf 1975, Stacey 1983: 48, Topley 1975) in Southern China although their number was very small. Daughters are thought not to share the responsibility of supporting their parents through their lives because they have to leave the natal household after their marriage (Ayscough 1938: 63, Stacey 1983: 43, Wolf 1972: 32-41).

This custom had generated many negative implications for women in general, e.g. it meant that a girl's birth is less likely to please her parents (Liu 1976: 72, Stacey 1983: 43) and that daughters are a poor economic investment for the family to bring up. The birth of a girl as the first birth might disappoint her parents, though it at least had proved the mother's fertility. When the time for the girl's marriage came, the bride's family would demand a high price of goods and cash to compensate the loss in bringing her up and the loss of a daughter and the loss of her labour power in the family. The payment of high bride price reinforces the view of women as commodities bought and sold by patrilineal families (Jacka 1997: 62).

It was common before 1949 that the parents of a girl would let her future parents-in-law bring her up, feed her and clothe her because she would eventually be wife and mother of that house and that was where she really belonged (Lee 1994: 71, Stacey 1983: 44). Her future husband's family would have the advantage of her cheap labour. She would be their son's wife. So years before marriage, she was received into her future home, there to help till the time of marriage came, when she would be welcomed in a more whole-hearted way. Child marriage was eventually banned after 1949, although the sale of young girls can still happen sometimes (Croll 1995: 128, Hall 1977: 119).

Nowadays the daughters of well-to-do families may attend better schools and have greater freedom. They can even be seen walking about in public with their boy friend's hand around their waist. The daughters of poor families have to assist in

¹ Some unmarried women in the South of China bought their independence from their natal and marital families with the wages they earned weaving silk in the early 20 century. They took vows never to marry and lived together (Stacey 1983: 48).

household tasks. The diversification of on- and off-farm activities in the recent economic reform created a great demand for labour in the countryside. One of the ways in which a peasant household can recruit additional labour is the recruitment of a daughter-in-law. This has led to reports of the sale and abuse of young peasant girls since 1949 (Croll 1995: 128, Hall 1997: 119).

It is observed that little effort has been made in the formal education system to teach a girl to be a good daughter, wife and mother (Croll 1995: 90-91, Tseng 1992: 81). Much of the energy has been put into women's preparation for productive roles. Many girls are eager to learn, to seek a real profession and to work out the destiny of their people but they do not have much idea of home making. They try to approximate the male standard of thought and life. In their profession they try to do men's work. They tend to have problems balancing their threefold duty to themselves, to their home and to society. These difficult problems are real concerns to many, but a solution may be possible for some of the more privileged women.

3.1.4 Women as wives and daughters-in-law

Lack of freedom to choose one's partner was common for men and women alike (Li 1992: 107) though a system of monogamous marriage, with a free choice of marriage partners was laid down by the Marriage Law in mainland China, Taiwan and Hong Kong in the twentieth century. Legislation or state ideology has never been translated directly and fully into practice (Blecher 1986: 152). Many marriages are still arranged in the old manner (Wolf 1972: 100-127). Old women rationalised that it was considered indecent for unmarried young people to meet each other and be friends before their marriage. They worried that the young couple were liable to take no account of the man's upbringing and social standing and to lead their marriage to separation or divorce in the end (Tseng 1992: 82). They were also frightened that a love marriage might shatter their son's loyalty to them and the security they had gained over many years by raising their sons. Many women's organisations and books about marriage advised young people to consult their parents over marriage — of course, without obeying them blindly. This realistic institutional adjustment was considered important for reducing future tension in the relationship between a son and his parents, and between mother-in-law and daughter-in-law.

Daughter-in-law in Chinese is *Xifu*, which literally means 'son's woman'. *Xifu* is used widely as a personal pronoun to address a daughter-in-law. This indicates her nameless status in a family and society. The relationship between a mother-in-law

and a daughter-in-law is usually regarded as a difficult one. In order to maintain harmony at home, one supreme task of a Chinese mother in the old days was to prepare her daughter to be a good daughter-in-law, before she taught her how to be a good wife (Ch'en 1992: 68). The hierarchical relationship between daughter-in-law and mother-in-law has changed little (Hall 1997: 97). A daughter-in-law was seen to have a chance of becoming a mother-in-law. The relationship between them after 1949 became more relaxed in urban areas because more and more married women are living in a different household, though there are indications that mothers-in-law resented working daughters-in-law who did not help in the house. The family tie remains close in rural areas because the majority of married couples remain in their husband's natal family.

Married Chinese women in rural China, Taiwan and Hong Kong alike were aware that they have to spend far more of their time interacting with their mother-in-law than with their husband (Wolf 1972: 142). Their duty, gratitude to their husband and his family, together with their social economic realities, did not give them many options or courage to break away from the family, if problems arose. This situation has prevented marriage breakdown, as women's own interests and freedom were restrained through self-control and self-sacrifice (Tseng 1992: 86). This is the reason that the divorce rate was kept at 0.85 per thousand marriages in 1982 and estimated 1.54 per thousand marriages in the early 1990s (Hall² 1997: 100-1).

The pre-1949 ideal of the woman staying at home was re-emerging towards the end of the twentieth century as the status symbol of wealth and leisure was changing from material possessions e.g. a refrigerator, washing-machines, television sets, cars and mobile phone, to the recognition of women remaining at home (Hall 1997: 66).

3.1.5 Women as mothers

The social position of a wife was raised if she gave birth to a son as the role of marriage was to keep up the family line, to continue her husband's ancestral worship, to complete her life and give her existence meaning (Davin 1976: 76, Liu 1976: 72, Ahern 1978c: 275, Wolf 1972: 142-157, Croll 1985a: 17, Hall 1997: 110 & 118). If a woman failed to give birth to a son, she ran the risk of being abused or divorced, although this is condemned by legislation. However this risk has increased

² Hall's study was based on her interviews in 1994 with 100 women from all walks of life, and official figures and statistics in mainland China

further as the result of the conflict between the State's one-child policy and the responsibility of producing a male heir (Jacka 1997: 65). The alternative solution to this problem is sex selection through amniocentesis, ultra sound scan and infanticide, which are reported occasionally (Croll 1995).

The birth of a son changes a woman's roughest stage in her life and gains her a position of some respect in her husband's family. Even when she obtained such a position she remained subject to the authority of her mother-in-law and her husband. If there was no old woman at home, she would be in charge of running the house, deciding what the family should eat each day and what each member might need. This in return would grant her a considerable power to reward and punish (Davin 1976: 76).

Becoming a mother means immense responsibility. She has to learn to manage the household, direct the upbringing of children and look after the elderly in the family (Liu 1976: 71-76, Tseng 1992: 86). The responsibility of a mother has never been relinquished. She has control over her children and her daughters-in-law. She directs the actions of her son and requires his obedience and expects obedience and respect from her children. Much can be read of the wisdom of the mother of Confucius and the mother of Mencius (Ayscough 1938: 300-3). The influence of a mother on her son is repeatedly noted in Chinese literature (Tseng 1992: 73). Even today most Chinese men still turn to their mothers with reverent adoration that is unfamiliar in the West.

The capacity of producing an offspring is both advantageous and threatening (Ahern 1978c: 269-290). This is true for the women in Taiwan and Hong Kong and also in mainland China. The mother should produce not only male children, but also strive to form close, affectionate bonding with her 'uterine family' as Wolf defined it (1972: 32-41) so that she could ensure a place for herself in the alien environment of her husband's home, strengthen her influence within the family and ensure security in her old age (Liu 1976: 5-6). Having children empowered her to fight for the separation of her own family from that of the in-laws.

Modern writers differ considerably in their judgement of the extent of a mother's authority in traditional China. The power of women with sons, although varying from case to case, was and is on the whole considerable according to Yang (1992: 29). The concept of modern Chinese women being 'good mothers' has remained strong since 1911, the early Republic era (Li 1992: 115). Mother's duties are

perceived as natural, biological and necessary in the social division of labour.

3.2 Chinese medical context

The health of a human being is seen by the Chinese as the responsibility of an individual. Prevention of diseases is achieved by living a quiet life; taking a cosmologically balanced diet and tonic drinks; and by being good to neighbours and other people. Many people in mainland China, Hong Kong and Taiwan know of these remedies and use them regularly according to how they feel irrespective of their background (Topley 1978a: 119-120). If any symptoms do arise they usually treat themselves by dealing with the 'predisposing factors' for example, the state of their mind, the balance of their diet or their environment. Emotional over-indulgences, such as anger, fear, grief or joy, are disease-causing agents. Anger or too much joy may cause heat in the liver and predispose a person to hot symptoms like fever, rashes, cough etc.; and fear or grief make people prone to 'wet' and 'cold' symptoms. Hot weather may predispose people to 'dryness', such as cold sores, headache, dehydration and haemorrhage; and cold wind, 'coldness/ wetness', like anaemia, rheumatism and arthritis. The therapeutic use of diet is further discussed in §3.2.2.

People in general have some ideas about 'constitutional disorder and the values of health care' (Topley 1978a: 118) in traditional theories of health and morality. This approach of self analysis, self doctoring and self guarding of one's health may lead them to be seen as 'hypochondriacs' (Topley 1978a: 120) by some Western health workers because they may not be able to understand why the Chinese seek medical advice and treatment, if their home remedies failed. Western medicines were perceived by many Chinese to be hot in Taiwan (Wolf 1972: 154-5). They are believed to alleviate the symptoms of an illness but not able to provide permanent cures.

3.2.1 *Yin yang*, five elements and related concepts in the perception of illness

The human body is thought to be dominated by the dual cosmic principle of *yin* and *yang*, the opposing but complementary forces (Topley 1970: 423, 1978a: 128, Unschuld 1985). Any disequilibrium of *yin* and *yang* and disproportion of the five elements (wood, fire, earth, metal and water) will result in disease. They are used to classify all aspects of childbearing, from conception to postnatal care and from daily activities to diet. The *yin yang* system is the most basic division of the cosmos in

traditional Chinese thought (Wang 762AD: 31). This dualism has operated within every entity. *Yin* originally meant 'shady'; is associated with the phenomenon of cold, winter, cloudy, rainy, darkness; and symbolises femininity and negativity. *Yang* meant 'sunny', is associated with heat, summer and symbolises masculinity and positivity. The *yin yang* system was thought to be environmental determinism by Dikotter (1992: 7-8) and a 'theoretical instrumentarium of Chinese medicine' by Porkert (1976:65-66). Many authors have addressed this natural philosophy in their works (Needham and Lu 1969, Topley 1970, 1978a, Ahern 1978a, 1978b, Tseng 1986: 275, & Anderson 1988: 188).

Yin yang and five elements are the essentials of the professional tradition of Chinese medicine, while 'hot' and 'cold'³ are popular among the folk tradition. This hot/cold folk tradition is reflected in Li's work (1596: 26-28).⁴ The basic five elements are regarded as symbolic representations of aspects of nature (Werner 1922: 84, Unschuld 1985: 59, Anderson 1988: 188), and have functioned widely within Chinese culture to think about complex sets of relationship between human beings, the physical environment, and chronological processes. They have been used as a theoretical instrument to experiment and work out correlations among phenomena, and sometimes led to the discovery of meaningful causal connections but they have also been used in a mystical manner (Topley 1976: 247). The concept of five elements incorporates the *yin yang* dualism and constructs physiology and pathology in Chinese medicine.

Disease manifests itself in the combination of two forms: *qi*⁵ (live force) and *feng* (wind), and the three pairs of symptoms: 'hot' (*re*), 'cold' (*leng/han*), 'dry' (*gan*), 'wet' (*shi*), *stuffy*⁶ (*shi*) and *weak* (*xu*). All these two forms and six symptoms stem from the basic concept of the five elements. These clinical signs and symptoms are diagnosed by eight techniques: *yin yang*, *biao-li* (exterior and interior)/*fouchen* (surface and deep-down), *xu-shi* (weak and stuffy) and *hanre* (chills and fever); and treated by four basic therapeutic principles: *han* (perspiration), *tu* (emesis or gastric

³ The terminology of 'hot' and 'cold' is regional. 'Hot' is widely used in Cantonese in the Southeast of China. The people in northern China relate the concept of 'hot' in Mandarin or northern dialects more directly to the higher level description of 'fire', which is one of the five elements rather than the folk or lower level 'hot' and 'cold'. The southerners use 'cool' and 'cold' very often according to the varying degree of the property of food and the northerners use 'cold' in a less elaborate way.

⁴ Li Shizhen based his work on folk tradition and more than eight hundred different *Herbal Medicine* books through the ages. He recorded 1892 herbs, of which 374 were recently discovered by him during his field collection.

⁵ *Qi* may refer to adrenal glands and their endocrine secretions in western physiological terms

⁶ The symptoms of *shi* in Chinese medicine usually refer to fever, absence of perspiration, constipation, abdominal distension etc.

aspiration) *xiae* (diuresis and bowel evacuation) and *bu* (strengthening one's health) (Guo 1979: 215).

One Chinese dichotomy about illness noted by Gould-Martin (1978) is 'from outside the body' and 'from within the body'. Illness from outside the body referred to the social, psychological problems which could be cured through sacred religious, ritualistic therapies. This was traditionally considered to be related to supernatural causes. Illness from within the body was the result of a physiological problem. With this problem people might seek secular medical treatment, e.g. herbalist, bone setting, acupuncture or a Western medical practitioner (Gallin 1978: 175). Chinese medicine focuses more on the patient than the disease.

Many Chinese nowadays still feel strongly that traditional Chinese medicine has an important contribution to make in health care, particularly in the care of chronic disorders. Some medical revivalists in China had been trying hard to develop and revive this ancient medical system of more than 2000 years old in an attempt to protect it from the threat of Western medical culture. Croizier (1976: 341) considered this revival of Chinese medicine was to create something new instead of restoring something old among the Chinese. Acupuncture without needles and head acupuncture to treat paralysis, dysphasia and dysphagia are the examples of this type of creation.

Chinese medicine is based on a different system of classification of illness and disorders in the human body from that of Western medicine. There is a close relationship between symptoms, causes and therapeutic principles of illness and diseases in Chinese medicine, which has been perceived by the Chinese as concerning the adjustment of the psychological balance of an individual. Furthermore, products in their natural state such as plants or herbs, animal and mineral substances are the major ingredients in Chinese medication. The effect of such drugs on patients is often mild and slow. These features, plus the sense of Chinese medicine as part of Chinese culture concerning life philosophy, may account for the survival and revival of Chinese medicine among the Chinese in mainland, Taiwan and Hong Kong, especially in rural areas and even among some people outside China.

3.2.2 Diet therapy

Food for the Chinese in general serves — as a therapy; as a means to health and longevity; as a preventative measure of illness and a method to diverge from psychological stresses (Anderson & Anderson 1977: 366). Traditional food rules call for a cosmological balance of 'hot' and 'cold', 'warm' and 'cool', 'solid' and 'weak'.

These three pairs of thermo-adjectives have nothing to do with the temperature or other properties of the food. It is their effect on the body that counts. Any imbalance of these three pairs is perceived as the disequilibrium of *yin* and *yang* (§3.2.1) and it results in disease. Chinese diet therapy is regarded as an art that has stood a trial for over 3000 years. In my experience Chinese people in China integrate their traditional dietary principles with guidance from modern theories of nutrition. They usually compromise their choice by avoidance when a conflict arises in diet selection.

Many foods are classified into *yin* quality and *yang* quality in China (Li 1596: 774:26-28, Miao 1644: 775-287, Chang 1977: 9-11, Anderson 1988, Anderson & Anderson 1977, 1978: 75, Ahern 1978b: 18). Anderson (1988: 192) suggests that the hot and cold system fits well with *yin* and *yang* theory and implies it is independent of *yin* and *yang* cosmology (§3.2.1). It can be argued that *yin* and *yang* is manifest in hot and cold. 'Hot' and 'cold' are lay terms which have survived and become popular not because they fit into *yin-yang* theory but because they are an inseparable essential element of the philosophy itself. The category of cold food was believed by Anderson (1988) to be different from cooling foods, but again this is not the case. Cold and cool are synonyms. The difference between them is the degree of coolness, in other words, cold is much cooler than cool. Hot and cold system is a simplification of the more sophisticated five elements.

The concept of the appropriate proportion of rice, bread or noodles, etc. and supplementary vegetable and meat is important. In fact it is another indirect way of balancing *yin* and *yang* or 'hot' and 'cold' in the lay terms (see §3.2.1, footnote 3 in this chapter). At a micro-level an individual will not feel comfortable and full without having rice or grain. A meal is less tasty without vegetable and meat. Common advice for a healthy diet among lay people is to eat 70 percent full (*qicheng bao*) in order to prevent overeating.

Chinese diet therapy has four features: (1) therapeutic relationship between flavour, colour and organ; (2) self-medication; (3) prevention of illness; and (4) *yin* and *yang* dialectical selection of a well balanced diet. The nutritious and curative effect of the five flavours (sour, bitter, sweet, pungent, salty) of food is related to the human five organs (liver, heart, spleen, lung, kidney) (Shi 1987: 4-9, Wang 762AD), the five elements of life forces and five colours as illustrated below.

Table 3 The relationship between 5 organs, 5 colours, 5 smells, 5 tastes, 5 elements and their *yin/yang* status

System	Status	1	2	3	4	5
Organs	<i>yang</i>	lung	heart	liver	spleen	kidney
Colours	<i>yin</i>	white	red	green	yellow	black
Smells	<i>yang</i>	stinking	burned	foul	sweet	rotten
Tastes	<i>yin</i>	pungent	bitter	sour	fragrant	salty
Elements		metal	fire	wood	earth	water

The cause of a symptom can be identified in relation to the organs of the body. The diseases of a different organ are cured by different foods with a different taste. A different flavour has its own therapeutic function. The liver requires a sour taste; heart, bitter; spleen, sweet; kidney, salt and lung, pungent (Li et al 1127, Wang 762AD).

Self-medication means one identifies a cosmological balanced diet for oneself in daily life according to her or his preference, geographical location and season (Shi 1987: 4-9). A person from a different region will receive a different kind of food for the treatment of the same symptom at a different season. The same food produced in different areas may have different properties and different medical effects. The choice of food is decided by the availability of food in that area, at the right season as well as by an individual's age, sex, preference and physique. A realistic well balanced diet varies according to individual understanding of these features. There are guidelines but not set rules.

Diet therapy is a convenient preventative measure in medical care (Shi 1987: 4-9, Sun 652AD). If one could use diet therapy to prevent and treat illness, one could make a very good doctor. The best doctors are those who can prevent patients from catching diseases, good doctors are those who can detect early signs and symptoms and ordinary doctors can only treat those who are ill (Guo 1119: 89).

A correctly balanced diet has to be based on the symptoms of the disease (§3.2.1). Different symptoms indicate a different diet, for instance, water melon and fresh lotus root are good for the symptoms of *shi*. Dried ginger, mutton, lamb, brown sugar are good for *xu* symptoms. *Yin-yang* should be identified within each symptom, such as *yin xu* or *yang xu*. In a *yin xu* case much more '*bu*' foodstuff should be applied than *yang xu*. In my experience most Chinese women have some ideas of what food is what, for example, kelp, mung bean, salad and fluid food are

well known 'cool' foods.

3.2.3 Health care services

The medical care Chinese women in this study had experienced before their migration was mainly of two major types: Western medicine and Chinese medicine. Western medicine is similar to that in the developed countries which started to enter China after 1911 through missionaries and Western explorers. The western medical practice in China is similar to the system discussed in Chapter 5.

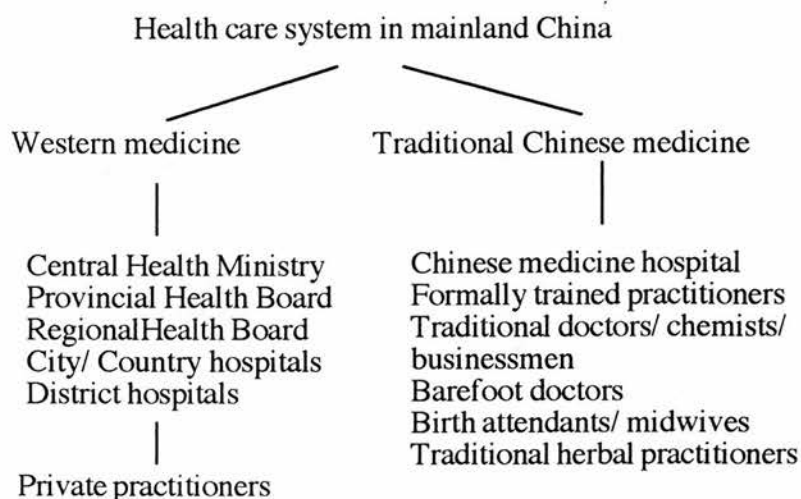
Chinese medicine is subdivided into licensed Chinese medicine and lay traditional Chinese medicine (Topley 1970: 422). Chinese medicine refers to that practised by the professional licensed Chinese, usually male medical practitioners. The lay traditional Chinese medicine refers to the medicine practised by lay people, lay midwives or birth attendants. The paternalistic approach in the gender division of labour within health care in China between Chinese medicine and traditional Chinese medicine is similar to that of Western medicine. Many medical practitioners actually use medicine from both traditions. Chinese medicine is more accessible to the rural population. The bio-medical model is better accepted by the urban and educated people, although they may also use Chinese medicine.

Chinese medicine embraces theoretical studies of health disorders, therapeutics⁷ and pharmacognosy⁸. The central concern of Chinese medicine is to adjust the psychological balance and the balance of *yin* and *yang* of an individual. The Chinese health care system in mainland China is similar to that of Taiwan and Hong Kong in which Chinese and cosmopolitan medicine are available. Six of the ten Chinese women in the study had experienced this type of care provided in the mainland before their migration to Britain. The health care system in mainland China can be summed up and illustrated in Figure 2 according to what I can understand from literature sources and my own experience of working as a barefoot doctor in China.

⁷ Therapeutics includes acupuncture, moxibustion (Counter irritation produced by igniting a cone or cylinder of moxa placed on the skin), dietary regulation, callisthenics (Gymnastic exercises of five animals, *taijiquan*, etc. to achieve bodily fitness and grace of movement), breathing exercises and massage.

⁸ Pharmacognosy is the study of drug ingredients of vegetable, animal and mineral substances used in their natural and unprepared state.

Figure 2 The health care system in mainland China



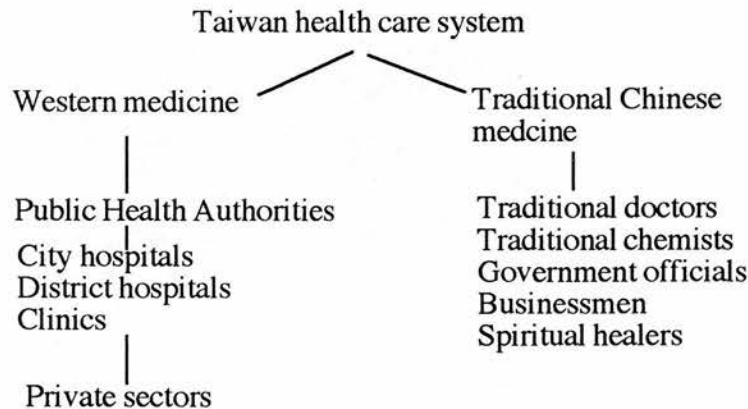
Barefoot doctor medicine was created as an 'effective' and economical way by the state in 1968 in mainland China in order to combat the acute shortage of medical staff and treatment in rural areas. It has been the most popular primary medical care available in the country areas as free state treatments are still not available for peasants.⁹ The clinic expenses were shared by local people annually. The staff were trained at local or provincial state hospitals.

In my experience the informal training of barefoot medicine had two major disadvantages: (i) it was not recognised professionally in formal institutions; (ii) it did not help barefoot doctors to develop an awareness of their limitations. Though barefoot medicine did help peasants to some degree, it appeared to be an irresponsible but cheap way to exploit the peasants in order to relieve the workload of the existing state medical system and burden of the state, that could hardly meet the demand. Barefoot doctors were high in political status in order to encourage them to serve the 'people' but low in professional status, just exactly the same as their peasant clients. Low professional status led to the decline of this newly emerging barefoot doctoring since the 1980s. The decline of village primary care forced higher educational institutions to open their doors to barefoot doctors to encourage them to stay on so that they could get more western training and maintain their professional status (Sidel & Sidel 1982: 41).

⁹ According to the state constitution in China land belongs to the state. The agricultural workers in the countryside in China can use their share of land to plant vegetables and grains but they do not own the land. Therefore the term of 'peasant' is more accurate than 'farmer'.

The existing literature shows that two health care systems of western medicine and traditional Chinese medicine co-exist in Taiwan urban areas, as illustrated below.

Figure 3 Taiwan health care system



Sources: Unschuld 1976:300-316, Gale 1978:275-288, Gould-Martin 1978:41-68, Ahern 1978a:101-110

The two systems in Taiwan have influenced each other (Unschuld 1976, Gale 1978). Many traditional doctors use Western diagnostic methods for example, X-ray, blood, stool, urine tests and stethoscopes and they also use Western therapeutic medicine occasionally. Some doctors with Western training show some interest in traditional drugs but the majority of them refuse to recognise the healing quality of traditional Chinese medicine.

The health system in Hong Kong is, according to Lee (1978) and Topley (1978), slightly different as it was a British Colony until 1st July 1997 (Figure 4).

Figure 4 Hong Kong medical care system



Sources: Lee 1978: 389-310, Topley 1978: 111-141

Though the political and social systems are different in Hong Kong, Taiwan and mainland China, the two major health care systems of Western medicine and Chinese medicine coexist in all of them with a different technical orientation and social organisation. This mirrors 'the multiplicity of ideological tendencies in Chinese society' (Unschuld 1985: 260). These two systems are competitive on an unequal basis. In all cases, Western medical practitioners take a dominant position while Chinese medical practitioners have only a marginal one. Traditional Chinese medicine is not well institutionalised. Patients are treated at home and traditionally medical practices tend to be handed from father to son, mother to daughter. However the practice of Chinese medicine is strong and growing stronger every year despite the strength and growth of cosmopolitan Western medicine in these Chinese communities. Many Chinese seem to turn back to Chinese medicine for selected medical complaints, especially after failing to gain relief from Western medicine.

There is evidence indicating the system of temple medicine and demonological therapy surviving on the mainland itself and still flourishing among the Chinese population of Hong Kong and Taiwan (Unschuld 1985: 260). However, Western medicine continues to be the standard for medical practice in all three areas. The technical orientation and social organisational patterns of Western medicine is further discussed in Chapter 5.

3.3 Women as patients

How women are seen and how they perceive themselves is the starting point of understanding women's position as patients. This section serves as a summary of the whole chapter.

China is an old country which has various conventions and traditions. The changes in mainland China, Hong Kong and Taiwan demand the willingness of Chinese women to face difficulties, to survive new challenges and adapt to new roles in keeping with the needs of the society with different political systems and ideologies. Despite the prevailing social customs favouring men, Chinese women's contributions to the family and society — as daughter, wife, daughter-in-law, mother and worker — have been gradually recognised by some writers explicitly or implicitly. Women's experiences of these roles from these three areas are similar, especially for the rural women.

Based on literature (Li 1992, Lee 1994, Croll 1995, Hall 1997) and my personal observation three changes have taken place in Chinese women's lives. The first is the change in moral conception. Though filial piety is still considered important, blind obedience to parents is no longer upheld. Marriage is looked upon as an institution founded on mutual love and help. A woman does not have to lose her individuality, her profession and her personal point of view after marriage. The second change is in the women's own perception of themselves and their lives. Many Chinese women nowadays are no longer content to live a restricted life at home. They are eager to learn to seek a career and live their life to the fullest extent, or they are hoping to be a lady of leisure at home. The last change is the change in the perception and treatment of women in Chinese society in general. Though it is still difficult for them to define freedom, to know exactly where individual freedom ceases and social restriction begins, Chinese women try to balance the freedom to develop themselves with the need to keep in view the good of all.

While some Chinese women today still see themselves as 'supporters' of their husband and their duties as within the domestic sphere, others, especially the younger generation, are more career-oriented, but on the whole modern Chinese women are seeking more independence and individuality. The educated no longer see inferiority in women, at least openly. Women have been encouraged to be good daughters, good wives, good mothers traditionally and selfless good workers since the beginning of the twentieth century in the interests of the country. The notion of this

three-fold duty — to themselves, to their home and to society— explicitly links together the public and private sphere of women's lives. In practice, male preference exists, in both family and society. The old perception of female inferiority has been revived to a certain extent since the 1980s, the political and economic reform in mainland China.

The deference of Chinese women to their husband, father, son and mother-in-law in authority, the three-fold duties to themselves, their home and to society, and three changes are the aspects which are most likely to be relevant to the experience of Chinese women in Scotland today. Son preference and the hierarchical relationship among women are also issues among Chinese women in the UK. Accordingly these issues are covered in the interview topic guide.

Like British women and men (Macintyre & Porter 1989) Chinese women's health in my knowledge is influenced by many factors, for example, their gender, their physique, their age, their social status and previous experience. In modern times, urban working mothers have to work forty to forty-eight hours per week. They have to send their children to kindergartens, nurseries or crèches before their work, and clean, wash and care for them after work. They have to rely on the help of their female relatives: mother, mother-in-law, sister, sister-in-law, or cousin who live nearby (Davin 1976: 185) in order to keep their jobs and at the same time maintain a certain standard of care for their children. In this context, their own health usually becomes their last concern, although women wage-earners have access to free or low cost medical services.

Rural women are dissuaded from using hospitals because they have to pay for their hospital treatment. Hospital health care is nevertheless considered better equipped with well trained staff and modern equipment. The treatments in the local and rural clinics are more affordable for rural women because the health workers there are less well trained and there is less travelling and expenditure involved.

In my experience it is not too hard for women to persuade people that they need care as they are perceived as weak, but they have to balance their domestic finances and house work before they seek medical care if they have to pay. If her mother-in-law stays with her in the same household, she may offer her daughter-in-law some domestic remedy at first instance. If it does not work, she may take over the domestic tasks while the daughter-in-law is away seeking medical advice and treatments. Treatment for women may be deferred if financial difficulty arises in the

household in two situations in my experience. First, they may opt not to go to hospital if possible, as the payment will force the family to cut down its expenditure on food or other daily necessities. Second, their family may take the woman to the hospital in an emergency situation but the hospital may refuse to give her treatment simply because they cannot provide enough evidence of their ability to pay. As the hospital is used only in emergency when all else fails, high failure rate is usually associated with hospital utilisation. This provides further justification for the reluctance of the women and their families to avail themselves of this resource.

I have also observed that the subordination and deference of rural women to men and elders in the family are also reflected in their ways of seeking medical care and treatments when they are ill. They are not used to questioning medical judgements but are ready to accept medical advice or treatment with a belief that doctors know best because of their training and their work. The unfamiliar environment of the hospital can often make them feel powerless. They often find themselves in an awkward position when dealing with hierarchical institutions and professionals compared with the local healers or barefoot doctors with whom they are more familiar. They are reluctant to use hospital services and Western medicine. This is not only the question of finance, but also the question of preference. Women's modesty may prevent them from consulting a male doctor or telling him a full story. They prefer consulting a female doctor about their condition. They feel more in control in general to receive treatment and rehabilitation from traditional Chinese doctors in the community.

The perception of women's diseases is structured and organised by Chinese cultural rules (Gallin 1978: 173, § 3.2). Their diseases were thought by ancient Chinese healers (Chen 1237: 480) to be ten times more difficult to treat than men's because women were more jealous and emotional, and their diseases were associated with blood, menstruation and unlike men's diseases, with *qi* (life force). The balance of blood and menstruation is the gender specific thing to tackle when treating a woman's disease. According to written records the Chinese medical practitioners since the Tang Dynasty (618AC) have tended to perceive women as weak, prone to diseases because of their physique, menstruation and childbearing, and thus in need of special medical attention. This paternalistic idea is one of the reasons why the treatment of women's diseases and childbearing has long been part of Chinese medicine (Chen 1237; Fu 1425a, 1425b).

Western medical approaches have persuaded Chinese women to some extent not to follow their old customs of health behaviour and childbearing practices, but

there is still resistance to these approaches. There is no doubt that Western obstetric technology has attracted more and more Chinese women, especially the urban educated Chinese women. But on the other hand, the women's participation in such a medical care and acceptance of new technology continues to be regulated by their traditional notions of health, medical care, social pressure, taboos, gossip and advice. These have become part of established patterns of social behaviour for Chinese women.

Chinese women in Scotland have to accept European medical care and such regulation becomes more subtle. The Chinese women I have interviewed in Scotland all showed that they used the binary principle of *yin* and *yang* at some stage to measure their health. This was especially true in their food habits. These are further discussed in chapters 7, 8 & 9.

In Chapter 4, traditional Chinese medical practices are further examined through a focus on childbearing, i.e. pregnancy, birth and postnatal care. How women perceive themselves or are perceived and treated in all these stages of childbirth is closely related to their social status and to Chinese obstetric medical concepts. My personal experience as a 'barefoot doctor'/ midwife in southern China is also drawn upon to illustrate and question the birthing experiences of Chinese women in China in comparison with those of the Chinese women in Scotland.

Chapter 4

Childbearing in China

Like the previous chapter this chapter seeks to elaborate the social and cultural context which the Chinese women in my study came from as migrants to Britain. Women's experiences of childbearing in China are examined through a study of some Chinese medical texts on pregnancy, birth, postnatal care in history as well as my personal experience as a barefoot doctor (§3.2.3) from 1970-1974 in the villages in southern China. My personal experience reflects the social and medical context I was in and the training I received during that period. This may help us to understand the cultural constructions of childbearing and of the health beliefs and health-seeking behaviours of Chinese women. This chapter also illustrates to some degree how the Chinese medical context influenced my thinking and my thesis. It provides a historical reference point to the understanding of the childbirth experience of the Chinese women in Scotland because some of the Chinese mothers in Scotland also came from a similar environment. This chapter is divided into three sections: pregnancy, birth and postnatal care.

4.1 Pregnancy

Conception is widely accepted by educated Chinese from mainland China, Taiwan and Hong Kong alike to occur as the result of fusion of sperm and ovum, but it is also believed by many Chinese that conception takes place when *yin* and *yang* meet together (Zhang 1368: 778-5, Ahern 1978c: 272 & 278, Dikotter 1992: 166). Chinese medicine interpreted the conception of a child as the mixture of female blood and the male semen. Semen was believed to be the seed¹ of a child, which starts the growth of the child. The retained menstrual blood became the body (bone and flesh) of a child. The uterus of the mother provides the fertile soil to nourish this new life during pregnancy. The blood that flowed out during childbirth and postnatal period was regarded as the residual of the process of the child creation. There are not many differences in people's beliefs and customs of pregnancy and birth but different

¹ The dynamic and active component of the seed of father and the passive environment of mother for the seed to grow in coincidentally match the old western idea. Conventionally the father was believed to provide all the inheritable aspects of the child in both cultures, also in Middle East (Delaney 1991: 8-9) and South Asia (Jeffery et al 1989).

degrees of variations in these three geographical areas.

Being childless was generally believed by the Chinese to have four basic causes according to literature available. They were, first, mispositioned ancestors' graves; second, the incompatible horoscopes of the couple; third, the cold and weakness of the uterus (Yu 1531: 356); and fourth, the ill health or ill behaviour of the husband or wife (Chen 1237: 742-602). According to ancient medicine men, there were ten causes of infertility: underweight (cold and weak blood), obesity (too much heat and too much water), cold lower extremities (cold uterus), too much heat in the spine (too much heat in kidney), anorexia (weak *qi* or life force of the kidney, weak spleen and stomach), tight or distended abdomen (weak or too much heat of spleen and stomach), jealousy (blockage of liver *qi* — too much heat), prolonged back pain (weak *qi* in *ren mai*, a channel to control women reproductive system), dysuria and foot oedema (weak bladder and kidney) (Fu 1425a:27-36). Pregnancy requires a relative state of homeostasis of 'hot' and 'cold' (Li et al 1127a: 773:122, Dou 1981: 181). This internal balance could be adjusted by the woman's dietary intake (Topley 1970: 426).

Pregnancy is discussed through health problems in pregnancy, sex of the baby, 'fetal education', adjustments in daily activities, mobility and diet during pregnancy and, finally, dangers of pregnancy.

4.1.1 Health problems in pregnancy

The 'minor complaints' classified in Western medicine during pregnancy are believed by the Chinese medical practitioners (Li 1596, Fu 1425a) to be caused by the imbalance of *yin* and *yang* (§3.2.1) physically and/or mentally. The pathological changes are thought to associate with the disorders of blood, *qi* (§3.2.1), and/ or internal organs. The principles of treatments are to adjust either women's *qi* blood or periods.

It was thought by Fu, a reputable ancient Chinese medicine man (1425a), that women required a strong *qi* of their kidneys to be able to conceive as kidneys are central for the balance of water, which is the vital of the five essential elements (§3.2.1). Once the conception took place the kidneys had an extra function to produce amniotic fluid and look after the well-being of this new life. Because the kidneys were overloaded with this extra duty, they neglected their routine important job, that was to look after the balance of the five internal organs (heart, liver, spleen, lungs and kidneys) and therefore some minor disorders occurred such as nausea, vomiting,

fatigue, etc. (Fu 1425a: 37).

Ancient Chinese medical theory regarded physical changes and minor complaints during early pregnancy as the result of heat from the blood in the liver (Fu 1425a: 37). It requires the woman to avoid excitement and to have cool and light food to balance this overheated state. Food choices and intake are the main things to be observed in Chinese childbearing. From the Western bio-medical point of view, the Chinese therapeutic relationship in food intake between flavour, colour and organ is not borne out, but some food-intake observances have become established behaviour among many Chinese women in childbearing. The healthy food observances are ways to compensate the loss of heat and energy in a woman's body during childbearing. The combination of food with medicine prevents illness and copes with the life-cycle problem like childbirth.

Chinese dietary theory in my view also provides a basis for some Chinese women to have *bu* food (§3.2.1), such as ginseng and some other herbal medicine already prepared by a pharmacy to strengthen their kidneys during their early pregnancy, if they felt weak; but they would stop having *bu* food after the six month of pregnancy in case too much heat would bring on a difficult labour or other problems. Dietary selection among Chinese women in Scotland during pregnancy is further discussed in §7.5.

4.1.2 Sex of the baby

The sex of a child was generally believed in Song dynasty (960-1279) to be decided by a suitable and satisfactory matching of a mutual

yin and *yang* (Chen 1237: Vol. 742: 600-601), though there was also a dispute about how the sex of the baby was decided (Yu 1279: 2). Some ancient health professionals thought to have a boy, intercourse should take place at midnight on the odd days after menstruation, and to have a girl, on even days (Yu 1531: 354). Some thought if a female experienced orgasm before the male, the female's blood would enclose the semen and form a male pregnancy²; if the other way round the female blood would be enclosed by semen and form a female pregnancy (Yu 1279: 2). Other scholars at that period disagreed (Yu 1279: 2-5).

² The view women need to have orgasm, a sign of heat, in order to conceive a boy, coincided with the same ideas in the west, mentioned by the second century physician Galen (Maclean 1980:105-154).

If a male pregnancy was desired, the man was advised to have a salty and alkaline diet (rich in sodium and potassium) six weeks before conception by some modern Chinese medical workers even after 1980s; and for a female pregnancy, a diet high in calcium, magnesium, sugar and acid (Hao et al 1981: 65-66, Ding et al 1986: 119). The traditional ways of sex predetermination, on the whole, are the timing of intercourse, desirability of female orgasm and the intake of acidic or alkaline food. They are applied mainly to change environmental factors to select the sex of the baby. These methods may influence the sex ratio before conception but they have not been systematically or scientifically proven.

When Chinese doctors were asked to discern the sex of a fetus, they could answer without hesitation simply based on the right or the left position of the fetal back (Needham 1973: 54 - 55). If it was to the left³, it was a boy; if it was to the right, it was a girl.

Some backstreet ultrasound scan and amniocentesis were reported in the late of the twentieth century widely deployed for sex determination purposes in the period around 15-25 week gestation (Croll 1995: 165-166), although government policy forbids the use of sex determination technology. Chinese demographers and media suggested that the high male sex ratio at birth (>110:100, which is 4 points above the international norm of 106: 100) has indicated that many women had undergone this sex determination test (Croll 1995: 164).

Male preference is also reflected in local government family planning policies (Peng 1997: 5). The couples who were allowed to have a second child (rural population, minority ethnic groups with population below 10,000,000) can no longer enjoy their privilege if their first child is a boy. The second child policy is only applied to those eligible couples who already have a daughter since 1994 (Su 1994: 80).

In general Chinese people think that having a son is good because his gender enables him to live up to his family's hope politically, to meet his parents' expectations, to bring honour and prestige to the family and to secure the mother's position at home and in the community; to provide an extra pair of hands for a peasant

³ The interpretation of Chinese values to the dualism of left and right is different from other cultures. There is no fixed predominance in the interpretation of left and right (Needham 1973:45, 57). The meaning of left and right is usually decided by the circumstances to bring out the structural correlation between the universe, the human body and society. For instance, in greeting, women cover their left with the right to show their respect. Men, on the contrary, cover the right hand with the left when they bow, but they cover the left hand with the right in time of mourning. In this case the left is associated with the auspicious and the right with the inauspicious.

family or a breadwinner for an urban family; to carry on the traditional ancestor worship; and finally to carry on their family name and when they grow up, look after their elderly parents.

Some village women I knew in the early 1970s were treated badly by their husbands and their parents-in-law simply because of giving birth to a girl. It was believed by the villagers that if the woman was deeply loved by her husband, she should be able to produce a male child. If not, she could only produce a female child or be childless (§3.1.1). Whenever the family was hoping to have a boy but could not get it, the woman was blamed.

4.1.3 Fetal education (*Taijiao*)

Many writers (HEC 1979: 1509, Martin 1990: 18, Dikotter 1992: 166, Chen 1727: 362-3, ACWF 1989: 23) have noted that some Chinese believed that the fetus could be taught by the mother's speech and behaviour. This is called fetal education (*Taijiao*). 'Antenatal fetal education' was thought to have some influences on the development of the fetus. It was assumed that the nature of the baby could be altered by the emotional or the physical state both from the mother and the outside world. To bear a pretty child the mother was advised to see nice faces and pretty pictures and stay around good looking people during pregnancy. A hairdresser was reported to have been convinced that having her second beautiful baby was simply because she was surrounded by good-looking people (Martin 1990: 18).

This 'antenatal fetal education' was quite popular among the upper classes during the Western Han Dynasty (206 BC-25AD) (Dikotter 1992: 166), and is still popular today among working people (Martin 1990: 18). Many pregnant women I knew would try to be free of worries, to put up some pretty pictures in their rooms and stay away from any noises and unpleasant surroundings in order to provide the best external environment for their future child. They would read some nice poems, listen to some soft music hoping their child would be able to be born wise, musical and correct in behaviour. This topic is further discussed in §7.4.3.

4.1.4 Adjustments in daily activities and mobility

During pregnancy, certain taboos and rituals had to be watched, avoided and performed, for example, anger during pregnancy has to be avoided as it was harmful to the liver which would affect the baby's health (§3.2). Another example was not to indulge in too much sex because excitement could create too much heat in the liver and

cause miscarriage and pre-term birth. Many restrictions placed on a pregnant women are designed to protect the fetus rather than the mother (Wolf 1972: 153).

Women were advised not to go out in the evening (Unshuld 1985: 533). Women should also not attend funerals or visit the sick during pregnancy, and especially not to be at the scene of driving nails into a coffin in case it might bring the woman and her child bad luck . If a pregnant woman was present at a funeral, she was given a red ribbon to tie around her abdomen to protect her and the fetus; a piece of ginger (the sign of life and heat), some pine leaves (a symbol of long life) and a small pair of chopsticks. All these things were symbols of a live human being, especially red ribbon, a representation of blood that was believed powerful and very undesirable and hated by the underworld's ghosts and evil spirits. When the corpse appeared she had to turn away so as not to look at it. In this way her presence would not be noticed by the corpse (Wolf 1972: 153-154).

Some Hong Kong and Taiwan women assumed *Taishen* ('*tai-shen, thai-sin*)⁴, 'the little placenta god' hung around the mother's bedroom and protected the fetus. Moving the bed or house during pregnancy was believed to make *Taishen* angry (Gould-Martin 1978: 51-65, Ahern 1978c: 273, Martin 1990: 17-8). Any misconduct in his presence might result in fetal deformities. If she sewed in her bedroom, she might stab him in the eye. If she cut, she might cut him a cleft palate. If she filled in a hole in the earth floor, she might fill in his anus. If she poured boiling water into a long unused basin, she might scald his skin. All these injuries would be reflected in the unborn or the new-born. In a way, as far as I can see, these customs were intended to stop women overworking in their own bedrooms after their retirement from daily routine. All these adjustments indicate the possible preventive measures that the women can take to maintain their health in a positive sense and to avoid the fears that the society imposed on them.

4.1.5 Diet therapy during pregnancy

The balance of hot and cold should be maintained all the time before and during pregnancy and the food selected by the women must be harmless to and agree with the body. A high protein diet was regarded as having some influence on the intelligence and appearance of baby. The details of observance during pregnancy are listed in Tables 4, 5 and 6 according to Chinese ancient and modern medical ideas.

⁴ Taishen was believed to protect the child and remained attached to the child's body until about four months after birth (Ahern 1978:273, Gould-Martin 1978: 51-65).

Table 4. Food to be avoided that affects both mother and the baby

Factors:	Reason:
spicy, greasy or smelly food	morning sickness for the mother, bad effect on the baby's temperament
watermelon	diuretic effect, cold in the 1st 12 w — diarrhoea/miscarriage
banana	cold — diarrhoea & miscarriage
tomato	cold — diarrhoea & miscarriage
mango, pineapple	hot — skin rashes in mother — harmful for the growth of the baby
crab	a transverse delivery & skin rash, asthma, an undesired gait for the baby

Sources: Dou 1981: 295, Ye 1978: 171

Table 5 Food to be avoided that affects the baby's well being only

Factors:	Reason:
scaleless fish	allergen, husky voice in baby
prawn	skin rash in baby
lamb/ mutton	epilepsy in baby
dog meat	a mute baby
liver of lamb	poor fetal health
wild birds' meat & wine	stupid or blind baby
rabbit meat, wild bird's meat	cleft lips &/ palate
mutton	sickly baby
mushroom,	miscarriage
baby ginger	polydactyly
wild birds' meat & thick broad bean	a freckle faced baby

Sources: Guo 1119: 89-114, Jiang 1368: 69, Yu 1531: 371, Ye 1978: 278, Dunn 1978: 157, Martin 1990: 16-18, Hu 1314: 10- 13, Shi 1988: 2-3

Table 6 Food considered particularly good for mother and baby during pregnancy by modern medical oriented sources

Factors:	Reason:
pork, chicken, beef, fish, egg, beancurd	high in protein
spinach, carrots	rich in iron
green cabbage, mushroom	rich in vitamin C
apple, pear, orange	ditto, mild
rice, flour, sweet corn, potatoes	rich in carbohydrate

Sources: Ye & Hao 1994, Li 1996: 128-130, Hao et al 1981: 88-92

There is a general belief among the Chinese that overeating should be avoided to prevent an over-weight baby (Dunn 1978: 157, Kleinman et al 1978: 143-173). The taste of a diet for a pregnant woman should be cool but not hot (Yu 1531: 354-5). This usually means discouragement of spicy and greasy food intake. The contemporary observances and taboos are obviously aspects of the belief in Chinese natural philosophy concerning the relationship between the human body and natural phenomena. Food restrictions were and are often created with some association of sound, images, symbols and imaginations to restrain women from consuming certain foods, mainly for the protection of the future child.

4.1.6 Pregnancy dangers and vulnerability

Among some Chinese a pregnant woman was not only the source of joy for her own family but could also be taken as the source of danger to the others (Dunn 1978: 154-155, Ahern 1978c: 287, Topley 1978b: 251). A pregnant woman was considered dangerous to children because she was polarised in the direction of cold and could make them sick (Ahern 1978c: 287, Wolf 1972: 137, Wolf 1974: 237). Her presence in a wedding was believed to be especially unlucky for brides and bridegrooms (*Chongxi*). Such a contact could bring a future miscarriage to the bride, quarrels, misunderstandings between the new couple or produce death in the bridegroom's family (Ahern 1978c: 287, Doolittle 1865).

The danger a pregnant woman poses to the couple at the wedding forms a sharp contrast with the danger of the dead for a pregnant woman at a funeral (Ahern 1978c: 288). This indicates the perceived vulnerability of the fetus and also highlights the complexity of gender relations in the area of childbearing. These notions, beliefs and practices are unknown to the western medical science in Scotland. The question in this study is how these notions or views affect Chinese women's activities during pregnancy in Scotland.

4.2 Birth

Childbirth has been regarded as women's business in Chinese tradition. The earliest Chinese medical texts, which appeared in about the fifth to the third centuries BC, explained the physiology of childbirth for the first time based on the principle of *yin* and *yang*. Chinese birthing practices and set prescriptions of herbal drugs used during childbirth were normally written and passed down within the families of medicine men. Some of them were later collected and written into books for private reference. Ordinary people had no access to the books, only some rich people or scholars.

In the Chinese emperor's libraries⁵, which were compiled in the 18th century, six Chinese ancient books, or rather, collections of birthing practices and prescriptions of herbal drugs for different problems during childbirth are found (Li et al 1127a & b, Guo 1119, Chen 1237, Fu 1425a & b). These books were written and

⁵ These are known as the 'Four Libraries' in Chinese history. The 'Four Libraries' was an attempt made by the Chinese emperor in the 18th century to have a nation-wide collection of all books in Chinese history which were considered valuable and orthodox. The collection included books of all subjects of all times in Chinese history up to the 18th century.

edited by some medicine men in the *Song* Dynasty (960-1279) and the *Ming* Dynasty (1368-1644). They were based on stone inscriptions and the previous works on traditional birthing beliefs, customs and medical practices and expanded with their own practical experiences. These works were considered invaluable assets, recopied by hand between 1773 and 1778.

From today's point of view, these medical texts contain material of medical practices mixed with beliefs and symbolism in childbirth. For example, a labour position from a diagram according to the time and direction in Chinese cosmology and calendar was prescribed alongside the drugs to be administered during labour. Incense was burnt to purify the room where labour was going to take place (Li et al 1127a, Vol. 2:2, 1127b). A labour had to take place in a certain direction according to the month in which the labour occurred.

The problems to be dealt with during labour were similar to those in today's midwifery. They included mainly management of preterm labour, malpresentations, induction, augmentation and acceleration of labour, the safety of the fetus, pain relief in the situation of abnormal deliveries and stillbirth. The approaches to deal with these problems were different from today's Western midwifery. There was not much surgical intervention in labour, but there were elaborate pharmaceutical interventions according to the balance of *yin* and *yang* to deal with various kinds of difficult labour, haemorrhage and retained placenta, etc. The medicines used are mainly herbs, food, wine, minerals and salt. They are prepared in the form of herbal drinks, powder, medicinal extract and plaster to facilitate or accelerate the labour and birth of baby and placenta.

The management of normal labour was neglected in those ancient medical texts as it was seen as a natural event, though it required care and attention. Nothing was mentioned on pain relief in a normal childbirth. As Chinese childbirth directly relates to the continuation and consolidation of its society, it is inevitably subsumed under the beliefs of the culture and society and sanctioned by the society. Normal labour was assumed to be safeguarded by following the diagram of labour positions according to the time and the directions.

Since the beginning of the twentieth century, Western medical practices brought by European missionaries have largely replaced Chinese medicine in China (see Unschuld 1985). The same has happened to birthing practices (Zhou 1994). In the 1950s, new methods of delivery were introduced all over mainland China. The so-

called 'new methods of delivery' were the practices of European countries. Hospital deliveries have become a dominant practice in cities. Many traditional birthing practices have gradually been discarded. In 1990s Caesarean section rates in some metropolitan cities in China have even surpassed those in European countries. In relation to this, there was also a revival of traditional Chinese midwifery and obstetrics in order to achieve the balance between Western and Chinese medicine (Li 1996, Li 1996, Peng 1997).

In south rural China, the area where I used to work in the 1970s, there were two types of birth: hospital and traditional home birth. There were no proper medical and obstetric records and not much formal hospital antenatal care at that time. The staff working in the both settings usually had no idea what kind of labour they might be called in to deal with. In most cases antenatal care was deferred to the family and the 'natural' course of events.

Hospital deliveries there differed from those practised in Scotland in three aspects. First, the application of analgesia was rare in most of the hospitals because most women and medical staff believed that the utilisation of analgesia during labour would do more harm than good to the baby. The infants whose mother received analgesia during labour were thought by the health workers slow to establish spontaneous respiration at birth, less alert, less brisk and slower to respond to light or sound. Mothers felt that their babies tended to be less cuddly, less consolable and more difficult to look after and that it took longer to establish their breast feeding pattern, which was vital in the countryside, as artificial feeds were more expensive and inconvenient. Second, there were no husband/ partner, family member or friend present during labour. This was due to the belief that the people present at labour may be in the way of medical staff, or carry some undesirable spirits and make labour more difficult. Finally breast feeding was the predominant mode of infant feeding among Chinese women, and breast feeding mothers relied more upon the advice and support of their female kin elders than that of trained midwives. This may have been due to differences in attitude, acute shortage of trained staff in hospitals and also kin are available in rural communities.

4.2.1 Birthing belief and preparation

Most primigravidae in the villages where I used to work in China were between 18 and 20 because 18 was the minimum age for marriage by law. The newly wed couple would be expected to have their child soon to start their life-long

investment in their children. It was rare to see births outside marriage at that time. If any conception occurred outside the marriage, a back street abortion or hospital abortion would be carried out long before the pregnancy became visible. The attitude of hospital staff was quite tough at that time. They demanded a marriage certificate before acceptance for an abortion. Public humiliation was the common tactic to deter unmarried girls and boys from engaging in a relationship resulting in pregnancy. The fine for a birth outside marriage was over 2000 *yuan* at that time which according to Su (1994: 87) has been rising from 3,000 to 30,000 *yuan* in the 1990s.

Childbirth has been and continues to be a great burden for the rural women of childbearing age in rapidly succeeding pregnancies though less so now with the family planning programme (Croll 1985b). The constant childbearing, childbirth and child-rearing age the women quickly, and sometimes even cost their health or life. Yet their future security and hope rest on their children. Women's future security is achieved only through their heavy and painful life-time reproductive work. In such a context women approach their family building like Indian women 'with deep seated ambivalence' (Jeffery et al 1989: 175).

4.2.2 Place of birth

To give birth in the fields was seen by the Chinese villagers I knew as an accident. To give birth in hospital was rendered too costly. This made a sharp contrast with the urban people, who would opt for hospital delivery. Many village women chose to have a home birth not because it was a traditional way of birth and offered individual care, but simply because that they were not able to afford hospital care.

Giving birth at home in their bedroom was a common practice in the villages. Their bedroom was believed to be the best place for this self-contained domestic private secret. All the home deliveries I attended took place in the couple's bedroom. The only places I was present and worked in were their bedroom and hall. I was always attended by an old woman in the house, if needs arose. I never had a chance to go to their kitchen or other places for any reason.

When labour was about to start, the door of the room the woman used for childbirth was closed. It seems that the women I attended, did not show too much respect to *Taishen*, the God of fetus for Hong Kong people mentioned by Martin (1990: 17-18) and Taiwan women by Gould-Martin (1978: 51-65) and Wolf (1972: 152-3). Before the onset of labour, the pregnant women I attended usually cleaned up the room, swept the floor, piled up a heap of straw ash for absorbing blood and

disposal of placenta. The unused furniture, new quilts, clothes and other used bedding were long removed before my arrival in case those valuables were contaminated by birthing pollution. It seems that they did not bother too much about the belief that moving any unused objects would injure *Taishen* and those injuries would be reflected in their unborn or new-born.

Clinic delivery was in fact something new for Chinese women since the beginning of the twentieth century. Some village women I knew then gradually accepted village clinics as places they could rely on for help. This was especially so in emergency situations.

4.2.3 Participants during the birth

Traditionally Chinese women in my knowledge expected emotional support from family members, close relatives and from midwives during labour. This practice can be confirmed by some literature (Li et al 1127a Vol.: 1-2, Holroyd et al 1997: 70). Birthing companions were normally minimised to one or two cautious and caring people because too large an audience would make the labour difficult (Li et al 1127a: Vol. 2: 11; Guo 1119: 89). Non family members or anyone who just came back from a funeral was advised not to be present at the birth in case they might bring bad luck and make the labour difficult.

The woman's mother and her mother-in-law were usually informed of the onset of labour. In my experience the woman's mother did not attend the birth in the countryside because the woman usually stayed and delivered her child in her husband's home. The supporting role was usually taken up by the mother-in-law as the child was seen as the descendant of the husband's family. In the absence of a mother-in-law in a household, a woman from the neighbourhood would come to help. The children of the family might be sent away to stay with relatives or neighbours because childbirth was seen as a private, dirty and shameful scene, which agrees with Wolf's finding (1972: 155) that parents would not like their children to see it as it might be frightening. In urban areas a woman, in my knowledge, most likely gave birth to her baby in hospital. Her mother might visit her there as her mother-in-law did when she was having or had her baby. The issues about support and ownership of the child became vague because the baby was not born in the husband's home and her own mother also had equal access to provide social and domestic support to her.

As far as I can remember there was no sign of any children and the other male members of the family around during the birth, such as brothers, father-in-law, etc.

But they were always available for summons at any time, if the need arose. In two emergency situations I was amazed at how quickly we got four or five strong men to carry the labouring mother to a clinic or hospital at night and early morning.

4.2.4 Labour management

The onset of labour occurs as the climax of a ten month⁶ pregnancy with a mixed feeling of excitement, anxiety and fear of the unknown. The village women I attended had no idea of the western medical concept of three stages of labour but it seemed that they had their rules and ways of coping with the same phenomenon. Show of blood, rupture of the membranes and frequency of pain were used as the landmarks for the adjustment of their activities and needs for assistance.

Mobility was usually encouraged in the early stage of labour at that time. This was in line with some ancient Chinese medicine men's advice (Chen 1237: 135, Yu 1531: 371-373) that if the labouring mother was able to walk, she should be encouraged to move around; if she had too much pain and could not move, but could stand during the contractions, she should be encouraged to stand.

The process of labour was thought by the Chinese mothers I knew to be allowed to follow the natural course in a calm and quiet manner. The birth attendant was usually old, respectable, reliable, careful and having personal birthing and experience of delivery. This practice agrees with some ancient Chinese medical texts (Li et al 1127a, Yu 1531:371). With her help there was no need to use augmentation because it was believed (Zhang 1368: 32, Yu 1531: 371-373) that if it was inappropriately done, a difficult, mal-presentation or transverse labour would be the result as the fetus had not been given enough time to rotate.

When I was called to attend to a birth, the first thing I did after arrival was to decide the position and presentation of the fetus and then I would assess my own ability to cope. If I did not feel comfortable to deal with it alone I would refer the woman to the district hospital. On most occasions the family refused to go to hospital and persuaded me to take her back to the village clinic. I could see some of the reasons for them to do so: (1) inability to pay the hospital bill; (2) free delivery at village clinic. They could enjoy nearly the same professional care as in a district hospital because as a barefoot doctor I could ask the district hospital for help free of charge as they had the

⁶ 28 days a month and 12 months a year according to Chinese lunar calendar

obligation to support this new co-operative medical system. This subtle way of working the system by the peasants provided me with an excellent opportunity to learn from experience.

In a difficult labour a neighbouring woman from the village, who usually was also a ritualistic or religious specialist, came to comfort the husband and family. Sometimes, she would prepare some special herbal tea for the woman during a long labour and advise the husband to burn incense, step over the woman's trousers and perform a symbolic ritual to support the woman and facilitate the labour. Sometimes the performance could be quite solemnly conducted.

In the villages, midwifery work for me as a teenager from the capital of the province was extremely difficult at first (§2.2), because the traditional midwife or birth attendant was usually over thirty and already had children of her own. The tradition and customs of the villages found it difficult to accommodate my 'deviant' behaviour. I had to face the hostilities of being indecent, violating female modesty, and interfering with the natural event of childbirth. I had to overcome much resistance and distrust from the clients, the formal trained medical staff in the hospital and the herbalists and birth attendants in the villages. The only advantage I had at that time was that my attendance or treatment was free.

It was not easy to work with the existing medical system, traditional birth attendants and old women, and I had to build clients' confidence with my good will. The medical system was strongly backed up by the state recognised certified professionals; and traditional birth attendants and healers had their solid community foundation and full support of their kin. The issue of which practitioners women choose highlights a contrast between women's deference to medical doctors, old birth attendants and their attitudes to a barefoot midwife.

In the first stage of labour, village women usually continued what they were doing before their membranes ruptured, until a show of blood, or the labour pain became intolerable. They believed if they discontinued their work earlier their minds would be at leisure and their body would be overwhelmed by this biological phenomenon. They would cleanse or wash themselves, prepare something light to eat, for example, rice porridge and retire to their birthing place if they felt they might lose their control and embarrass themselves in front of others.

The popular pain management in labour was to change and adopt a most comfortable position for the labouring mother. She was encouraged to do breathing

exercises, support her back and self-massage during the contractions. Women played an active role in their pain management. They breathed through the contractions. As the whole extended family were in the same household, most women tried not to make audible noises that would 'shame' themselves and their husband.

This culture of shame transformed the experience of pain in labour. The women I attended knew that they had to deal with their pain on their own during labour, if they wanted to have a family. They had to learn to accept suffering as an inevitable part of their subjective reality. If they lost control and screamed they would be reminded of their shame. In this way labour pain was made tolerable by integrating it into such a meaningful system (Illich 1975: 93). The attitude of this self-effacement and self-control constructed the duty, hope, responsibility and virtues of Chinese women and enabled them to confront labour pain with dignity and shape their experience accordingly. This formed a sharp contrast with the modern medical view that suffering was unnecessary because pain could be technically removed by drugs or anaesthetics.

When the contractions became expulsive or the membrane ruptured most of the women would stop walking or wandering about in the room and retire to their bed. If they did not I would advise them to do so to prevent cord prolapse, especially in the cases of parous women. On most occasions women preferred a semi-recumbent or supported sitting position to squatting, kneeling or standing. They had no idea of what the medical second stage was but they had a pretty clear idea when they were going to see their baby. The labour proceeded in the same manner as that of the Western approach except the midwife did not instruct and organise the woman to push during the second stage of labour. The pushing was organised and conducted by the labouring mothers themselves. They followed their body inclination to start with one short and brief push with each contraction and gradually increased the strength, length and frequency of their pushing according to the intensity of their contractions. During the pushing I have never seen any women use their own hands to touch their perineal-anal areas in my presence. They tried to avoid contact with their blood, liquor and the baby until the baby was cleansed and dried.

They changed their birthing position frequently. Usually they sat with their hands holding their knees, or supporting their back pushing with their knees and legs wide apart. Sometimes they sat at the edge of the bed with their hands supporting their back, breathing deeply according to their contractions.

Without any window the bedroom was so dark even in the daytime that I could hardly see the woman's face. It appeared that the dusk in the room conveyed to them a sense of calm and security and shaded away their vulnerable inner selves. The conversation between the woman and myself reduced to minimum, when she was engaging in pushing. Whenever the conversation started, it was always very brief and precise exchange of information, explanation or instruction. It was always the woman who started the talk first, when the contraction was over. Very often she apologised for the noises she made or the behaviour that she did not want to be seen by the second person in a normal situation. It seems to me she did not like the idea of squatting because that position was thought to exert too much gravity to control the speed of birthing and result in a fast delivery, perineal tear or a shock to her baby. Perineal tears were minimal. There was only a few first degree tears which did not require suturing. This may be because of a smaller baby, women's frequent and long hours of work and semi upright position during delivery.

As the baby's head was born, excess mucus was wiped from the mouth. After the birth the baby's airway would be cleared with the aid of a mucus extractor and mouth cleansed with a gauge swab. Most of the babies established breathing unaided. If the baby did not cry, I would dry the new born with a paper towel and clap its foot. Then I used my index and third fingers running along the cord and squeezing the blood towards the baby in a hope this extra volume of blood flow would start the baby's breathing. If this trick did not work, I would hold the baby's feet and hold it upside down. The last resource was to use one hand to hold both legs and the other to support the back of the neck and the head and both hands moved toward each other as if to fold the baby to compress the heart at the rate of 100 times per minute. I was advised this way of resuscitation was much safer than external cardiac massage because cardiac massaging could very easily apply excess pressure and cause rib fracture, lung and liver damage. Mouth to mouth resuscitation sometimes had to be applied because there was no oxygen supply at all. I placed a single layer gauge swab over infant's face and placed my mouth over the baby's mouth and nose and blew gently into the baby's airway at a rate of 20 breaths per minute and allowed the baby to exhale between breaths. Naloxone might be used in clinics. All babies responded to these measures quickly.

After breathing was well established the umbilical cord was cut, tied and dressed. The baby was checked, wrapped and chlormycine or tetramycine eye ointment applied to both eyes once only to prevent ophthalmia neonatorum especially the possible blindness in future caused by maternal gonorrhoea. The care of the new-

born would then be taken over by the family.

The placenta was usually delivered 15 to 20 minutes after the birth of the baby. My left hand rested on mother's abdomen to feel contractions and guide the mother to push and the right hand was free to wait for the descent of the placenta. After the placenta was delivered, I examined the placenta and membranes and disposed of it onto a pile of straw ashes prepared in the room long before the establishment of labour. No ergometrine or oxytocin was given before the complete expulsion of placenta because it was believed it might cause the constriction of the cervix and induce placenta retention. Ergometrine 0.2mg was given intramuscularly to treat or prevent primary postpartum haemorrhage. The immediate care of the mother was to help to clean her and tidy up. This usually took about an hour or so after delivery. Before the departure I checked the woman's fundus, uterine contractions and blood loss.

The villagers believed that the placenta was polluting (§4.3.3) and had to be disposed according to the diagram of labour position and place (Li et al 1127a & b) and buried deeply separately from the domestic refuse in case the village dogs and cats found it. However it was, at the same time, regarded as a drug both in Chinese medicine and traditional herbal medicine. It can be used in three forms: cooked with Chinese herbals and served as a tonic food (*bupin*), baked dry, smashed into a powder form and then made into tablets and distilled to make human albumin placenta injection. The indications for this drug are anaemia, malnutrition, peptic or duodenal ulcer, neurasthenia, gastroneurosis, oedema, hepatocirrhosis, etc.

Childbirth was seen as the woman's private business by my male colleagues and it was considered very embarrassing for them to look after the birthing business of the wives of their village neighbours. They might be afraid of birthing pollution but no one ever mentioned that. They were quite willing to help me in any way but not in the labour room. There was only one occasion as I remember, when I managed to call one of them to come into the labour room to give an injection to the mother in order to stop primary postpartum haemorrhage.

The birth of the baby is a signal of the end of pregnancy. The birth of the first baby boy signals the achievement of a new heir in the family and indicates a new social status for the mother. The birth of a new-born to a family already with several children is just another indication of further suffering.

4.3 Postnatal care

Relatively speaking postnatal care in China has been written about more than pregnancy and birth. Forty-six signs, symptoms and treatments were identified in Fu's works (1425b: 1-50). In summary these postnatal complaints were clots, haemorrhage, dysuria, anuria, oedema, constipation, diarrhoea, infection, various kinds of ache and pains, etc. The advice for the family was never to forget the needs of the mother when the family were overjoyed with having a baby; and for the mother, never to forget her own tiredness when she was looking after her baby. Some popular Chinese handbooks (Dou 1981, Ding et al 1986, Li 1996) on postnatal care have appeared since the 1980s, but they are mainly constructed in accordance with Western medicine. There is a difference between what people really do during the postnatal period and what they are advised to do in those books despite some recent attempts (Pillsbury 1978, Neile 1995, Cheung 1996a, 1996b, 1997) to help people gain a realistic insight into the postnatal needs of Chinese women.

There is no routine postnatal domiciliary follow-up care in the Chinese formal medical care system, although hospital care is promoted for the women during their pregnancy and childbirth (Hall 1997: 131). The professionals of Western medicine in China are taught that the old Chinese customs of *zuo yuezi* (sitting in for the month) are not only unnecessary but can be harmful. However all women from my experience adhered to their elaborate traditional customs and practices of 'sitting in for the month' after their childbirth despite the great effort made by the medical professionals.

4.3.1 Adjustments in daily activities during the postnatal period

The custom of *zuo yuezi*⁷ (§9.1) is practised by all Chinese women after their childbirth. It is similar to old Scottish 'lying-in' in the 18 century (Schott & Henley 1996: 172, Enkin et al 1995: 345, Tew 1995: 147, 152-3). Like the South Asian women in east London (Woollett & Dosanjh-Matwala 1990) Chinese women place a great value on rest and recovery from the birth through following their

⁷ There is a newly developed practice called *zuo xiao yue* means to sit in for the small month not directly after a childbirth but after an intended termination of pregnancy (TOP)). Because *zuo xiao yue* is not directed after a childbirth but a TOP, this month is considered smaller but it does not imply any less importance. This practice was reported by four of the Chinese women in my study from mainland China (W4, W8, F1 & F6). It is thought to be created by the women with 'wind' syndrome with a hope to have their diseases cured. Usually the women were entitled to have two-week recovery leave by law after a TOP, then they had to request another two weeks sick leave to 'sit in for the small month'. They used this opportunity to follow rigorously all the postnatal rules and restrictions they could in order to cure those postnatal conditions.

customs.

The only paper on *zuo yuezi* available to me was 'Doing the month' by Pillsbury (1978); but 'doing the month' is not the correct translation. Chinese word 'zuo' in the phrase '*zuo yuezi*' means 'to sit'. The pronunciation of *zuo* can mean both 'to do' and 'to sit', but they are different in written Chinese characters. Furthermore, to translate '*zuo yuezi*' as 'doing the month' can be confused with another occasion called 'doing the full month' (§9.7).

Pillsbury (1978) reported on the postnatal customs of *zuo yuezi* from her participant observation and interviews in Taiwan with over 80 Chinese people from different provinces of China and some Chinese physicians and herbalists but she did not specify how her sample was selected and how the interviews were carried out. Chinese women were found to confine themselves to the house, refrain from washing their hair, touching cold water and to adjust their dietary intake during the month according to their traditional philosophy of *yin* and *yang*. Because Pillsbury has limitations of language, she was not able to contextualise some apparently obscure or indistinct details. She misunderstood 'sitting in for the month' for 'doing the month' and unfortunately used it as the title of her paper. The picture she gives to readers is that Chinese women would not wash, bath or cleanse themselves for the first month because of those taboos. In fact, a Chinese woman who is in postnatal confinement does so every day in a modified way (§9.3). There is a difference in my experience between bathing, washing with a basin of water, and wiping/sponging oneself with a wet towel. Ideally, bathing is not performed, but a postnatal woman usually wipes herself, or somebody else wipes her with warm boiled water or hot water soon after birth. She continues to do this daily or every other day. Guo (1119: 90) advised women not to use cold water to wash or bath themselves because cold water imbalances *yin* and *yang* and makes them prone to diseases. This implies that Chinese women did do some washing and bathing postnatally.

The practices of *zuo yuezi* constituted ideal behaviour for women postnatally and real behaviour often deviated considerably (Pillsbury 1978). In fact all these prescribed or proscribed rules are practically achievable and followed according to the understanding and convenience of the women. All the women I looked after in 1970 to 1974 sat in at least for the first month, although the family might not be able to afford all the nutritious food they were supposed to have. *Zuo yuezi* was one of the few times in a woman's life when she can be assured that she will be waited on by her mother-in-law and for a brief period relieved of all household responsibilities (Lau

The practice of *zuo yuezi* has been developed to such an extent that a *zuo yuezi* centre was mentioned by three Taiwanese mothers in the study. It became a good business in Taiwan because more and more couples work away from their natal villages or hometowns. Many of them had no parents around; so they had to go to the *zuo yuezi* centre, a place somewhat like a hospital, which helped the new mother to sit in for a month, to look after the baby, to cook and stew *bu* food for herself.

4.3.2 Diet therapy for women during postnatal period

Three principles are frequently used, both by traditional medicine men and lay people, to measure a woman's diet after giving birth to a child. They are *bu*⁸ (§3.2.1, §4.1.1), *quyu huoxue*⁹ (removing blood stasis and promoting blood circulation) and *qufeng* (dispelling the 'wind' syndrome¹⁰) to facilitate a quick recovery of the mother's health in terms of strength, hot-cold balance, pollution from childbirth and to ensure lactation and baby's well being.

Based on literature (Li 1596 a, b, c) ginger, honey and *nuomi tianju* (glutinous rice wine) are thought particularly good at *qufeng* to get rid of the 'wind' syndrome, help the circulation of *qi* and relieve fatigue. Fresh ginger root and/or wine are 'hot' medicine as well as an additive to food. They can be cooked together with rice alone, with meat or with small amounts of rice wine in chicken stock in my midwife experience. Garlic is secondary to ginger, but both of them are widely consumed during the postnatal period.

The basic diet of a mother in southern China is boiled rice, soft or dry noodles, meat broth and other dishes mentioned above. In the north¹¹, flour products such as *mantou* (steamed bun), *huaquan* (steamed twisted roll), *laobing* (pancake), *jaozi* (dumplings) are the main substitute of boiled rice and noodles. Vegetables to be

⁸ Most *bu* foods are easily digestible, and contain high levels of protein and vitamins. *Bu* foods often have striking colours, such as jujubes, carrots and spinach. All animal meats are regarded *bu* to some degree, and it is commonly accepted among Chinese that the part of the animal consumed strengthens the same part of human body. *Bu* food includes red meat, fish and sea food, poultry, beans, products of soybean. Papaw, chicken, octopus and fish soup are thought especially good for lactation and the baby's health is bound up with the mother's diet once breast feeding is established.

⁹ *Quyu huoxue* is often achieved through diet therapy combined with administration of the Chinese herbs. *Dangshen* (*codonopsis pilosula*) and *danggui* (Chinese angelica) are two plants on the border between food and medicine for women in childbearing. They are cooked with chicken or any kind of *bu* food. They may be made into a herbal tea or drunk in powder or taken in a tablet form.

¹⁰ Wind syndrome refers to chronic headache, backache or rheumatic aches and pains (Eisenbruch 1983).

¹¹ North China: the areas on the north bank of Yangtze River, including the Yellow River plains and hills around them, the zone of dry farming

avoided during the postnatal period are cucumber and bitter melon because they are too 'cold', and chilli and pepper because they are too hot. Fatty, spicy hot food and cold food (§3.2.2) are normally avoided by a woman for at least a month postnatally.

In southern China the mother was given a special diet of chicken cooked with ginger, vinegar and wine. Sometimes she was given a boiled fresh water fish because this fish was supposed to help in the production of breast milk. She had also a special chicken dish, well cooked to make it extremely tender and sliced into very tiny pieces. All her food had to be very soft and was generally well cooked. The broth of various kinds of beans is good for prevention of a hot syndrome in the baby (Li et al 1127: 24).

The meals in the first postnatal week are crucial. Chicken broth, pig feet (Li 1590: 774-417) or spare rib soup will form part of every meal to promote lactation. Pig's spine and thigh bone are also important ingredients for making soup for postnatal women. When the mother's milk comes in and the breast feeding pattern is established, the diet will be relaxed a little.

Chicken broth is valuable for women to recover from childbirth (Anderson & Anderson 1977: 369). This is a must, especially in the first week after childbirth. Ideally in a better-off family, 30 chickens may be prepared for the mother's consumption during the 30 day period after birth. Each day the breast of a chicken together with red meat and certain vegetables are prepared for the mother's consumption and the rest of the chicken is used for the other members of the family. In a less wealthy family, at least half a dozen chickens are prepared during the first postnatal month.

It was common that a mother in the countryside usually ate her meal in her own room, away from the rest of the family, or at different time. There are two explanations for this practice. First, separation at eating time or place can minimise the 'birthing pollution' spread to the rest of the family. Second, it is good to avoid distraction, ensuring that the mother has some peace to enjoy her food, recover her strength and consolidate her breast feeding role. Also, in the situation where the family cannot afford to eat the same food, the mother may find it difficult to enjoy her food in the presence of their children.

Chinese people perceive certain herbs as good for health as food. They called these kinds of herbs *buyao* or *bupin*. This kind of tonic substance entails no distinction between food and medicine. This may be equivalent to the modern concept

of 'nutritious' in English but different in the sense that the substance is medicinal at the same time. The common *bupin* for the postnatal period are dry longan pulp, brown sugar, Chinese angelica, ginseng etc. Traditionally women will not feel comfortable if they have not had three courses of *shenghuatang*¹², which is considered to be compulsory in a traditional Chinese community to prevent or help after-pain.

4.3.3 Postnatal pollution

Chinese women were regarded as potentially ritually polluting due to their childbirth blood, fluids and postnatal discharge (Ahern 1978c: 269-290). There were three types of blood in women: flowing blood, menstrual blood and birthing blood (lochia) (Ahern 1978c).

Flowing blood was thought useful for women's body building and it has a direct effect on the baby's well being. Menstrual blood was seen as useless, unclean and bad that the body had to get rid off (Dunn 1978: 158). The retained menstrual blood was thought useful because it became the body of the baby. The concept of pollution of retained menstrual blood might come from its association with the death of mother, the child or both according to Ahern (1978c: 274).

Lochia was considered to be the cause of many diseases, and to be more poisonous and vile than menstrual blood. According to Ahern (1978c: 270) people who had contact with lochia and menstrual blood were barred from worshipping the gods, although in practice not everyone was prevented from worshipping the gods on this account. In order to minimise childbirth pollution the couple was advised to avoid sexual intercourse for the 100 day period postnatally (Guo 1119 Vol. 6: 89) and to avoid nursing the child during postnatal bleeding period (Topley 1970: 427). A male disease called *so-lo* was noted by Topley (1970: 424) as the result of intercourse with a woman within a hundred days of childbirth. It was thought to be caused by *taidu* (womb poison) and regarded as fatal without prompt Chinese medical treatment.

In my experience the husband's mother or an old woman in rural areas in China usually stayed with the new mother during the first month after childbirth, assisting with housework, looking after her and ensuring her swift recovery. Another role of her staying was to ensure in one way or another the husband would not resume

¹² *Shenghuatang* is a set prescription of Chinese medicine. It has Chinese angelica, motherwort, safflower, dangshen (*codonopsis pilosula*), huangqi (the root of membranous milk vetch/ *astragalus membranaceus*) etc., and contains herbs of ergometrine. The number and the amount of herbs are prescribed according to the woman's physical and psychological condition.

his sexual relationship with his wife too soon and be contaminated by lochia.

The concepts of the flowing blood, menstrual blood and birthing blood metaphorically were an expression and reflection of women's social role and their social activities. The end product of pregnancy was an offspring who was desirable for both the woman and her husband's family (Ahern 1978c: 273-274). The idea of postpartum pollution is disappearing since more and more women are now having their babies delivered in hospitals. When a child was born in a hospital, only the birthing room was polluted. The woman could leave the pollution behind when she returned home. This may be one of the reasons that Chinese women prefer hospital birth to home birth, like travelling people in the UK (Okely 1983: 85).

4.3.4 Child care

There are elaborate accounts of the care of the new-born until the age of one year in traditional Chinese medical texts (Guo 1119: 2-21, 90-114). The care of a healthy new-born within the first month is the focus of discussion.

The perception was that the baby's safety was ensured by the removal of all mucus, blood or meconium in the mouth with a piece of silk wrapped around the finger because if they got into the abdomen, the baby was prone to diseases (Guo 1119: 92). The new-born was cold (Guo 1119: 90-91). The cord should be cut off by teeth with a piece of cloth around it rather than be cut by a knife or a pair of scissors because knife and scissors were 'cold'. The cold status of the new born could not accommodate the coldness of knife and scissors. When the cord was cut by biting, it should be left six inches long. If it was left too short, it was harmful for the baby's internal organs and the baby tended to have diarrhoea. If the cord was left longer than that, it was thought harmful for the abdominal muscle. If the cord was left intact, the uncut cord could cause 'wind' which might get into abdomen and predispose the baby to diseases. If the cord did not get cut at the right time, it could leak and end up with *qifeng* 'cord wind' (umbilical tetanus).

The benefits of colostrum are new ideas in China. The term of colostrum is not in the vocabulary for the village women I knew at that time. The mother usually fed the new-born with some honey or sugary water in the first 12 hours post the birth then expressed the first few drops of milk from each breast and discarded it. The first few drops of colostrum were believed to have no nutritious value to the new-born. If the mothers felt they had not got enough milk, they normally topped up the new born with some thin porridge made from some grounded newly harvested rice with some

sugar or honey. They were also advised not to give the new-born too much honey and water because it could cause indigestion and make the baby's spleen and stomach too cold. Urban women preferred bottle feeding their baby in hospital to breast feeding until their breast milk was in. Then they started to feed the baby themselves in the belief that it made no difference whether the baby was breastfed on day one or day three as the colostrum was always stored in the breast if no milk was expressed. Mixed feeding was common if the woman had a hungry baby.

The baby's well being was bound up with the mother's health and her emotional state. According to literature (Guo 1119: 90), the mother should express and discard some of her milk before each breast feeding when she was hot, otherwise her baby would appear yellow and have poor appetite. If she was cold, she should do the same or her baby would have loose stool or diarrhoea. If she was angry during feeding, her baby would be disturbed. If drunk with alcohol, her child would be hot and suffer indigestion. Chinese mothers were reluctant to use the overnight expressed breast milk to feed the baby.

New-born babies should not be bathed too often and kept in a bath for too long in case they caught cold. The door and windows of the room should be closed during bathing, and changing nappy and clothes especially in the winter. The first bath for the baby was normally done by the birth attendant or the midwife with some warm boiled water or herbal water. Then the mother-in-law or an old woman from the village would take it over from there and hand over the care back to the mother after her sitting in for the month is completed (Guo 1119).

From the same source the new-born should have no visitors and stay in with its mother for the first month because the visitors might bring some bad luck and make the child prone to asthma and other diseases. Spicy, greasy, sour dietary intake of the mother and sexual intercourse would endanger the hot and cold balance of the new born through overheated mother's breast milk.

The beliefs and practices mentioned above are interwoven with ideas about baby care and ideas about protecting the mother and the child from diseases and from misfortune. The guardian of these traditions are the woman's mother-in-law, mother and grandmother. Although the woman might not agree with her elders' view at the time, they would accede to their elders' wishes, so that tradition and domestic harmony are maintained.

4.4 Summary

From pregnancy to postnatal care, childbirth in traditional mainland China, Taiwan and Hong Kong alike was tied up with various beliefs in the basic *yin* and *yang* principles. This is most obvious in the diet of women during pregnancy and especially in postnatal period. The regulation of diet between ‘hot’ and ‘cold’ food is a way of compensating for the loss in women’s body to ensure the health of the baby through the health of the mother and her lactation. Food restrictions in association with sound, images, etc. do not receive support from today’s point of view, but such restrictions become a way of life in many circumstances in the culture with a long history. This can readily account for some of the food habits of the childbearing Chinese women in Scotland.

Antenatal care was not as widely available in the rural mainland China as that of the urban areas, Taiwan and Hong Kong. It was carried on in the form of fetal education, dietary, mobility and social observances. There are taboos and observances for women and for the public in general during pregnancy, such as pregnant women being the source of danger to others, postnatal pollution, etc. Although such beliefs and practices may not be popular today after a century of constant cultural change, their revival in certain areas and in certain individuals persist even in urban and well developed areas.

There are three main differences between home deliveries in rural china and that of the UK: absence of analgesia, few partners presence in the birthing suite and more home births. The emphasis of Chinese maternity care falls on the baby care indirectly in the forms of fetal education during pregnancy and the care of the mother postnatally, though they are not formally recognised in the institutional care. Breast feeding is predominant though bottle feeding is increasing in the urban areas. The birth practices in China are far less interventionist, which is associated with the limited resources and medicalisation there — although there were traditional interventions.

Chinese communities are heterogeneous and diversified in China, Hong Kong, Taiwan and the UK. They have different perceptions and preconceptions of childbearing. This review provides many potential questions for this study on pregnancy, birthing beliefs and practices. When Chinese women in the UK confront a new culture of birthing practices, some of them may lean back on their cultural birthing customs and practices, and follow what they are familiar and feel secure with. Some of them may have to incorporate western ways and their own values to create a

way to express both; and others may adopt the local customs and practices.

The birthing customs, practices and everyday experience of Chinese village women mentioned above suggest that we may find in Scotland the Chinese women grown up in China present themselves with a different baseline picture of a likely childbearing experience than a British woman may have; the use of some alternative coping mechanisms, such as food therapy, self-effacing, self-control, etc.; a tendency not to seek Western medical advice, antenatal, postnatal care and treatment promptly and little expectation that their experiences and needs should be recognised in professional care because childbearing is regarded as a private business.

Chapter 5

Childbearing in Scotland: Social and Medical Context

This chapter is built on the literature available rather than on my experience as a midwife and intended not only to present the context within which the childbirths in my study took place but also to provide a point of contrast with Chapters 3 and 4. This can indicate how the participating women negotiate and strategise their choices and options of care in childbearing and how they are likely to have different experiences in Scotland. Although some British studies included may not refer to Scotland specifically, they are useful as Scotland is part of Britain. This chapter is divided into three sections: the social position of women, medical context and the women's experience of childbearing.

5.1 Position of women

Scotland is more urbanised and industrialised than mainland China and Taiwan though it may not necessarily be so than Hong Kong. Childbearing in Scotland was and is related to women's social positions and to the gender/ family relationship though it has less connection with ancient or traditional beliefs and practices concerning both health and gender than that in China. In order to facilitate a comparison this section is to review women's position in a similar format of previous chapters in terms of women's social roles as workers, daughters, wives, daughters-in-law and mothers. These comparative categories of social identities are arbitrary constructs, which may not have the same meaning in these two cultures.

The locus for a married Scottish woman in the family is a wife and a mother even though there is a tendency for her to get married later and to wait longer to have children compared with a Chinese woman, who is more likely to be a daughter-in-law and then mother-in-law in her old age. The meaning of having children is different in Scotland from that in China in a number of subtle ways: giving less importance of extended family ties and responsibilities and more emphasis on romantic love and the marriage bond. It is worth noting the continued view of children as the normal consummation of a heterosexual love relationship, which is still the favoured context for rearing children — even though marriage seems to be in decline.

5.1.1 Scottish women in society in general

Although there are class and regional variations in how much women did remain in the home at different periods in reality, the view that women should be at home, bearing children and doing housework had been held well into the modern times by most Scots as the other British people according to Lynn Jamieson, the British sociologist (1997: 17), who critically examines the notion of intimacy about the relationships of family, friendship and sex in a personal life in contemporary societies. The interests of the child were given a prominent place in the temporal dimension of social relations by 'the ideology of the child-centred society' (James & Prout 1990: 1), which emerged post World War II because of the decline in population (Lewis 1980).

The notion of individuality for Scottish women is similar to that of Chinese women (§3.1.1, §3.1.6) in the sense that the concept of self is constructed by division of gender and age, which attaches to the biological and sociological aspects of femininity and domesticity according to the British medical sociologist, Ann Oakley (1974: 40, 70, 1980), who has written extensively about British women and their emotional responses to childbearing. Scottish women have choices and equality but disparities in pay and limited opportunities in practice while Chinese women have a sense that they must work in private and public spheres in order to contribute to society to maintain financial independence and public identity in Scotland. This double shift is also common among Scottish women. On the whole, compared with the Chinese women both in China and in Scotland, the different features of Scottish women are the western notion of autonomy, privacy, the idea of self-development and the need for an expression of individual uniqueness.

5.1.2 Women as workers

The industrial revolution has brought about social changes in Europe and European colonisation of other countries overseas. 'Family', as part of the social organisation of human activity, has become a nuclear childrearing residential unit segregated from wider kin, the social life of the locality and the major forms of economic life (Harris 1983: ix). The proportion of the women working population has been steadily increasing up to nearly 45 percent in the UK in 1998 (ONS 1998: 149). British women have expectations of what they want from their working life and many are determined that these expectations be met (McDougall & Briley 1994: 9).

As the result of industrialisation, Scottish women no longer have to do all housework, although the quality standards of housework are still to be seen as a symbolic expression of the woman's affection for her family (Wajcman 1991: 85). The Parsonsian ideal-typical family (1956) with a full time mother and a male bread winner seems to be dated and less plausible (Jamieson 1997: 18). Childbearing may disrupt women's careers because of motherhood as a big responsibility which demands sacrifices and time (Moss & Brannen 1987: 37, Harris 1983: 73). This interruption affects their chances of reaching a high position in their profession when they resume work (Harris 1983: 73) although it is now much more common than ten years ago for women to take a short maternity leave rather than a career break (McRae 1991: 4). The level of women's jobs in term of pay, skill, prestige and responsibility still remains significantly lower than that of men (Wajcman 1991).

The analysis of women's experiences of the incompatibility of motherhood and paid employment can never be entirely separated from the other variables such as class, educational level and ethnic origins. Middle class women may be in a better position in their choice of paid work or staying at home during pregnancy and after childbirth, because they have far greater access to resources which make this possible. Single parents may be compelled to take up employment by their domestic financial state much earlier than they originally expected but many of them often have to stay out of work because they cannot find higher paid work that would allow them to pay for child care.

5.1.3 Women as daughters

Before the beginning of this century daughters in all but wealthy Scottish households were expected to be the major contributors to the mother's work in the home and care of their siblings and other family members. Each urban or rural household has its own norms concerning the duties of a daughter to her parents, but in general daughters are socialised to be more gentle, quiet, tactful, home oriented, more expressive, less adventurous than their male counterparts (Nicholson 1990: 65). The early learning of domestic skills and the feminine gender roles from mothers is an ever lasting lesson for daughters.

Cohabitation of a couple is now a common practice for women to negotiate relationships with their partners in order to search a more individualised, self expressive, self reflexive and self fulfilling way (Jamieson 1997: 19). The pursuit of this 'pure' equal relationship (Gidden 1992:58) has brought some social changes. The sense of right and

wrong has become known to them to be socially constructed such that 'today's right answer is tomorrow's mistake' (Jamieson 1997: 22).

The duties of a daughter toward her parents are not emphasised as much as parents' duties to child. They tend to be both emotional and service oriented (Lopata 1987: 387). The amount and type of support provided by a daughter depends on the mother-daughter relationship and many other factors. In practice the daughter is usually the most important supplier of support to ageing parents and especially to widowed mothers. The value of a daughter to her parents in Scotland can be appreciated through a remark that 'a daughter is a daughter for all your life and a son is a son until he takes his wife' although the parents are not as economically dependent on their children as in China because the employment is linked with company or state pensions for their old age. The duty of a daughter to care for her parents is in contrast with the Chinese culture where the son is expected to do so (§3.1.1, §4.1.2). This is one of the reasons why sons are more desirable than daughters in China.

5.1.4 Women as wives¹ and daughters-in-law

Marriage remains the acceptable destiny for many women (Harris 1983: 16-29) but their family position shifts from conventional male centred Victorian type of family to modern companionate type of family (Finch & Summerfield 1991: 7-32) which is based more on a love developed in a relationship (Jamieson 1997: 14). Men are expected to take their share of work in the home although available evidence indicates they do not do so equitably (Wajcman 1991: 87, Richardson 1993: 15). Men usually do little of the unpaid work, child care work in the home, perform non-routine tasks at intervals rather than continually; and often their work is outdoors. Women's and their partners' relationship to housework and family position are not equal.

In medieval times middle class women at home as daughters and wives were in a situation of 'double dependence — both on God and on their father/ husband according to Gittins (1985: 38, 40), a feminist writer in her analysis of the dynamic family ideology and the reality in the light of available literature and findings. Traditionally before marriage, women should obey their parents and after marriage they should submit to their husbands (New Testament: Ephesians 5: 22-33, 6:1). This is similar to the 'three obediences/ dependencies' prescribed to Chinese women in Chinese history (§3.1). What is different is

¹ The terms 'wife' and 'husband' are used in the widest sense to include 'as if married' relationships.

that there is no prescription for a woman to obey her son and that at the same time the Church asks husbands to love their wives (ibid.). A spiritual Scottish woman, like others in Christian societies, was one who was a pious mother and wife, always serving her family to the best of her ability, obedient to her husband and God according to the belief, values and ideas of the Scottish society. Economic supremacy, political power and religious control were all defined with reference of the father, who was the authority directly from God and at the same time the head of a household, whose members were dependent on his protection.

The two mythical images of evil Eve and asexual Mary created in the Bible remain strong symbols in Western culture and can still be seen influencing and informing the attitude of the women (Gittins 1985: 39). Women's sexuality can be religiously acceptable by denying their own sexuality, yet passively accepting their husband's sexual 'needs' and by being mothers. Therefore traditionally and culturally women have been conditioned to passivity and the career of housewife.

Wives contribute to the husband's occupational career in the role of homemaker and that of wife by housekeeping and ensuring that the children do not interfere while he recuperates from the strain of his job. There is a social class and regional variation in how women perceive their roles in relation to their husband's career, ranging from nagging him to work harder on the part of the least educated wives, to direct involvement by the more educated wives of men in business and professional occupations (Gittins 1985: 123). The women married to 'important' men make efforts to maintain the family's status in the community through club work, voluntary activities and friendships, socialising children and women to a manner the society expects of them.

A Scottish woman no longer lives under the same roof with her or her husband's parents on marriage. Her life becomes much easier without the immediate intervention from her mother-in-law or her own mother. But their presence could be important in many ways in childbearing: as an important source of female company, substitute carers if the partner was not available; a resource available during the day when things were going wrong and an important person with whom to share childrearing concerns. This is similar to Chinese mothers in the sense that the extended family network provides support for child care but it is different from that of China, where the workplaces provide nurseries and kindergartens although these are not common in rural areas. The rising needs of her own mother's help in Scottish single parent families is the result of the limited state and workplace provision of child care in the communities. Nevertheless, there are significant

tensions with regard to the woman's mother or her mother-in-law's involvement, which may prevent the woman from developing her own independent judgement, expertise and threaten her maternal authority.

When children are grown up and out of the way most women expect the role of wife to return to its primary position. Thus this implies a conflict between the role of mother and that of wife, in addition to major life changes for the woman from her prior involvement and self-concepts (Lopata 1987: 390). The successful outcome is to have companionship and security as well as affection.

5.1.5 Women as mothers

The mother status can be obtained through giving birth, adoption or marriage to a child's father. The duties and rights of motherhood vary considerably by the community, the location the mother in it, her age, marital status, child's gender and birth order. Becoming a mother is a complex experience (Oakley 1979, Lopata 1987: 398), which requires constant reconstruction of reality and of the self. Women who refuse to become mothers are seen unfeminine to deprive themselves of their responsibility, joy and suffering as a mother. Their choice brings themselves social disapproval - at the very least it demands explanation in a way that the choice to have children does not.

Mothers are expected to be primarily responsible for the care of their children as a labour of love and duty (Richardson 1993: 2). 'The core of the female tie to the home is not housework but children' (Oakley 1980: 96). The fantasy of being a perfect mother generates fear and a recurrent tendency to blame her for all kinds of failure (Lopata 1987: 399). In her study of fifty married urban women, Boulton (1983) found some British mothers enjoyed their work of child care but many did not. For these women, pregnancy, birth and day to day care of a child were an exhausting experience especially for first-time mothers combining child care, paid work and household tasks. It was a lonely and isolating experience for them because of the changes in patterns of family and domestic life during this century. The family now becomes smaller and their geographical mobility makes the home a much more private place. There are fewer people likely to be around to talk to and help. The relatives or extended family members often live some distance away though telephone has shortened the perception of distance.

To be alone with their babies for most of the day with plenty of time to think is a problem for many mothers (Richardson 1993: 12-16). They may feel anxious and

frightened of the responsibility associated with looking after a child. For some mothers the opportunity to spend time alone may be a time for rest from responsibility or from a boring low-paid job. They may not like the men to take equal responsibilities for child care because the opportunities for sources of status and power outside the home for women are restricted compared to men; they may feel threatened by the idea of men encroaching on what they regarded as their territory.

Society has not provided enough support for mothers in terms of limited child care facilities and insistence that mothers should be the exclusive caregivers of their children. There are only a few state funded nurseries and limited provision for those over three, despite the effort of the Labour government in 1998 in Britain to bring more women with dependent children into the workplace. Research evidence shows that kinship network provides help in the absence of a state or a husband support (Lopata 1987: 399). Middle class mothers in Britain may be able to afford an au pair, a nanny or a private nursery, while low paid or unemployed women have to rely on friends, or family or an inexpensive child-minder. Women who are in positions of having the help and support of a partner, family and friends, or having enough money to be able to afford to pay someone to look after their child, are more likely to get pleasures out of looking after their children.

The responsibility of motherhood reinforced women's traditional role of mother in the home (Brannen & Moss 1987:126). They welcomed the paid maternity leave, midwife's antenatal and postnatal visits and state economic assistance in the form of free milk, free prescription, free dental treatment and family allowances. Women who wish to remain independent and to devote most of their time to a career, are still faced with the dilemma that achieving these goals is extremely difficult if they have children. This does not only involve physical difficulties but also disrupts men's earner or provider role in the family (Jamieson 1997: 19). They welcome part-time paid work or job-share schemes available for them after having their families. Although women in Britain can derive status from paid employment as well as motherhood (Homans 1982: 235), some postpone their re-entry into the employment until their child or children reach school age, if domestic financial situation allows or if other alternative working schemes are not available.

The diversity amongst Scottish women is similar to that of urban and rural women in China. As a result, the gendered family life is now seen further by academics here as largely the problems of 'intimacy', the close relationship between persons which holds the key to social cohesion, to most aspects of social life, including childbearing and parenting (Jamieson 1997: 10-11, 28). Obviously, childbirth in Scotland is now part of that story of

‘the sociology of intimacy’, which will be understood in relation to the childbearing experiences of the women, discussed in Chapters 7, 8 and 9.

5.2 Medical context of childbearing in Scotland

Childbearing was treated primarily as a medical problem in Britain, the influence of the medical profession in formulating maternal and child welfare policy was particular great (Lewis 1980: 19). This reflected in the belief of ‘scientific’ appraisal and technological intervention in terms of safety (DoH 1993a: 29). Hospitalisation of childbirth is also noted to distance the women from their traditional social support network as a result of industrialisation and nuclear family structure. However there was a growing consumer pressure in response to challenge some aspects of the assumption of hospital safety. The choices in the type of maternity care for women were in increasing demand (Kitzinger 1987: 157- 161, Tew 1995: 133-134, Campbell & Macfarlane 1987, HCHC 1992a, DoH 1993a: 1).

Huge changes have taken place in maternity services since the establishment of the NHS in Britain (DoH 1993a: 1-3). The changing force is driven by not only approved ‘scientific’ evidence but also the existence of controversies (Jordan 1978: 66-89). It has changed for midwives, GP, and obstetricians in terms of technology, mortality rates, birthing practices, antenatal and postnatal care. It has changed for women in terms of a different experience of having a baby from that of their mother’s generation and a smaller size of family in the 1990s.

Different people have a different orientation and different methods of approaching the process of childbearing, even though they are mutually dependent and contestable. The professionals are part of the health care system rather than independent of the system. They have to perform within the professional acceptable codes and standards which enable the system to function effectively. Childbearing women have to come under the authority of and are dependent on the expertise of health workers to a considerable. This raised an interesting question for my study whether Scottish or Chinese women are likely to be more deferential to doctor’s authority. The Scottish medical context is thus further discussed in three aspects: (1) the medical model, (2) the midwifery model, (3) Inter occupational rivalries.

5.2.1 The medical model

Childbearing in Scotland is embedded in a medical culture like that of the rest of the Britain. Many critics are sceptical about medicalisation of maternity practices (Illich 1975, Macintyre 1977, Oakley 1976a & b, 1979, 1980, 1984, Enkin & Chalmers 1982: 267, Oakley & Houd 1990, Kitzinger & Davis 1978, Kitzinger 1987, 1996, Faulkner & Arnold 1985, Faulkner 1985). The first systematic meta-analysis of the research in this fields was published in 1989 to provide further evidence that there was no proven benefit for many interventions (Chalmers et al 1989). These critiques highlight a similar theme about the medical power relations.

The medical model of childbirth is shaped by the ideology of the medical science and the approach of reductionist and linear thinking (Bayne-Smith 1996: 35). It tends to prepare obstetricians to focus on the mechanistic view of body and problems and discount the feelings and emotions of their women and to dismiss any inclusion of the effects of social, economic, political, environmental and cultural forces from their diagnosis and treatment recommendation. This leads to a heated debate about the validity of this knowledge on which diagnosis is based and through which intervention is justified (Zimmerman 1987: 447).

Childbearing was regarded as a bodily function with anatomical, physiological and biochemical components rather than a life event that includes body, mind and spirit. It is 'safe' only retrospectively by the medical paradigm (Wagner 1994: 30 & 37). It requires a careful evaluation of an individual case for problems, monitoring and then followed by scientifically controlled correction of the bodily malfunctions of the process of pregnancy and birth. Antenatal education developed in 1911 was based on this assumption of risk identification to prevent problems before they arise, to provide a rationale for service planning and resource allocation, to promote the ideals of self-help, and to emphasise the importance of parental and especially maternal responsibility (Freidson 1970 & 1975, Gerhardt 1989, Wagner 1994: 28-29). The assumption of childbearing as a potential problem is in fact the extension of medical power (Oakley 1982). This can be dangerous for women because many women labelled as low risk may have problems and those thought to be at high risk may turn out to have no problems. There is a tendency that high risk status has been applied generously to more and more women over the years (Oakley & Houd 1990, Towler & Bramall 1986, Wagner 1994: 99). Empirical evidence from the works mentioned above suggested an increasing awareness of the error of classifying all

pregnancies and births as being 'risk' and 'high risk', which subject all women to the indiscriminating modern technology screening and monitoring.

There is a tendency to the centralisation of obstetrical services for safety, cost and effectiveness in the industrialised world despite a decrease in the number of births and a dramatic fall in perinatal mortality and despite the lack of evidence to support this move (Campbell & Macfarlane 1990, Tew 1995). In order to reduce perinatal mortality rate obstetricians develop and apply obstetric technology, take responsibility for the progress of labour, and expect their junior doctors and midwives to act as their deputies (Kitzinger et al 1990: 152, Bennett & Brown 1989: 3) in accordance with the policy. Their approach is enshrined in regulations. They use authority of knowledge to sanction the classification of normal or abnormal labour and thus to warrant intervention. Implicitly they see themselves as active agents, their patients as passive objects and midwives as their assistants to monitor the progress of pregnancy and labour (Tew 1995:7, Keirse et al 1989: 806).

Hospital becomes more and more intensive and specialised. Professional interests in specialities have brought in paediatricians into delivery area or elsewhere on the hospital site to provide emergency resuscitation of the asphyxiated baby and give the baby immediate care (Speidel 1987: 203-249). Paediatricians take over the baby's care from the obstetricians and its mother as soon as the baby is born. Their claims of expertise produce fragmented, narrow and repetitive work tasks and deskill the obstetricians from looking after the new-borns. Together with obstetricians, paediatricians develop a relationship with the fetus with the assistance of many radical fetal monitoring techniques (§5.3.1). They see the fetus as the separate patient and the mother becomes a potential barrier to the optimum medical care of the fetus. The conflict in this situation has recently been dramatised in court authorised caesarean sections (Rothman 1987: 163, RCM 1998a & 1998b). The medical professional believed that court ordered caesarean sections against the women's will were to improve standards of care for the women and their family but not a violation of their right and control of their own body if they were considered incompetent.

The relationship between the women and their babies, medicine, and health workers are changing with the increasing development of fetal advocacy, fetal right (Rothman 1987: 164), 'medicalisation of life' (Illich 1975: II) and dependence on the medical profession. On the one hand the medical interventions of some pain relief, instrumental delivery and artificial feeding have their place in obstetrics but on the other hand they can also introduce some undesirable complications (Tew 1995: 33). The medical 'iatrogenesis' (Illich 1975: 13-28) is the by-product of medical treatment. Medical

technology is used as an instrument of professional power both within and outside the profession; and as a tool for controlling women in life events: birth control, abortion, childbirth and menopause (Kitzinger 1977, Kitzinger & Davies 1978, Romalis 1985: 184, Oakley & Houd 1990).

5.2.2 The midwives model

It is arguable there is a midwives 'model' of childbirth in the way that doctors do because midwives operate in a tension between the medical emphasis on danger and pathology and a more traditional but easily romanticised emphasis on birth as a healthy life event.

On the professional rivalries midwives have regulated their professional skills in negotiation with medical professional bodies and the government and kept on improving their training since the beginning of the 20th century (Tew 1990: 7) by increasing its specialisation and ranking of specialties as the result of increased centralisation (Murphy-Black 1992: 114). The specialties of midwifery have been divided according to different stages of childbearing, namely, the midwives of antenatal clinic/ ward, labour ward, postnatal ward, neonatal ward and community. They have shaken off the lower status of birth attendants, handywomen and untrained helpers and enjoyed more respect and greater independence of practice in domiciliary deliveries than these groups.

The division between the areas of competence and responsibility is often not clear cut. A large grey area has given rise to conflict between the expectations and the practice of care and demands flexibility from all parties concerned. Midwives are expected to possess attributes of flexibility, cheerfulness, sympathy and empathy in addition to high moral qualities (Towler & Bramall 1986: 247). The limitation of the midwife's autonomy was more apparent in the larger hospital (Mander 1993a: 372). Many basic aspects of the management of labour were decided by medical personnel or hospital policy, for example, artificial rupture of membrane, type of analgesia etc. Changes in the medicalisation of childbirth led to specialisation or a fragmentation of care (DoH 1993a: 38).

The paradigm of continuity of care/r seems to be able to maximise individualised satisfaction both for women and the carers. This is what is called team midwifery (Murphy-Black 1992: 123) — that is a combination of continuity of caring and continuity of carers. The ideology of team midwifery is regarded as a process of professionalisation within midwifery to regain aspects of professional autonomy, status and job satisfaction

that have been lost by working in a hierarchical setting dominated by obstetrics (Sandall 1995: 203). Some prospective studies in midwifery suggest that the approach of team midwifery care has benefits for women in terms of providing advice and emotional support (Robinson 1989).

Autonomy and continuity of carer were the best predictors of midwife's job satisfaction in a study done on the midwives in Aberdeen (Hundley et al 1995: 171). The approach of team continuity of care claimed by midwives may not necessarily give greater choice and control (§1.4, §10.4) for women who have to rely upon midwives' expertise. The assumption that a female dominated midwifery service is able to provide more 'women-centred' care (HCHC 1992a) is still in need of systematic examination and evidence (Sandall 1995: 206). The struggle of midwives to achieve professional power and status may also produce unequal relationship that already exists between obstetricians and the mothers (Sandall 1995: 206). To achieve 'woman centred care' requires midwives to give up some of their autonomy and job satisfaction in order to create an equal relationship with the women. This requires a great commitment, resources, planning and considerable tolerance from the professionals. Continuity of care/r sets off a great task for the improvement of future maternity services to narrow the difference between what the women expected and what the services can offer.

5.2.3 Inter occupational rivalries

Childbirth in Scotland presents a picture of a struggle of claiming a control over childbirth among obstetricians, general practitioners and midwives, who represent different societal interests in birth.

The place of birth has become the centre of the power struggle. The hospitalisation for births has been an effective means to reduce the power and status of midwives as independent practitioners, because they have to work under the direct supervision of obstetric team. This strengthens the doctors' ascendancy over midwives as professional rivals (Tew 1990: 7). The professionals' rivalry has led to a redistribution of intraprofessional responsibilities (Schwarz 1990: 57) among the 'cure' and 'care' sections which indicates the claims of interventions to reduce perinatal mortality and the evolution of evidence-based practice (Cochrane 1972: 3, 85). The introduction of midwife-led clinics is used by midwives to reclaim their status, autonomy and power. Three randomised trials of midwife-led units (Tunbull et al 1996: 213-218, MacVicar et al 1993, Hundley et al

1995) and one non-randomised unpublished study have provided research evidence to justify and quantify midwives' claims (Campbell & Macfarlane 1996, Campbell 1997: 10).

The relationship between doctors and midwives is recognised to be highly charged and traditionally antagonistic by some qualitative studies (Donnison 1988, Ehrenreich & English 1973, Towler & Bramall 1986). Negotiation and bargaining about roles have been continuing throughout the hierarchy both in history and at the present time. Many disputes take place around the classification of the territory between 'normal' and 'abnormal' pregnancies and births. The definition of midwives' 'normal birth' is political and implies a different professional relationship. It assumes all pregnancies and births normal until proved abnormal. This approach assumes the responsibility of midwives and it is up to them to decide when to involve the medical care. The medical model assumes that all pregnancies and births are potentially pathological until proved normal (Wagner 1994:30). This approach assumes doctor's responsibility for the process of childbearing. The 'natural' interpretation of 'normal' is thought by Kitzinger (1990: 153) to be used to justify women's and midwives' resistance to medical interventions.

Shared antenatal care is a prominent and problematic model in the UK (Turnbull et al 1996: 213). Under this system the care of high risk women is assigned to the obstetricians, and that of low risk women to the GPs in the community with intermittent assessment by the obstetrician. 98% Scottish women attended their GP for shared antenatal care (CRAG/ SCOTMED 1995: 21). Both GP and the obstetricians may or may not delegate responsibility for low risk women to the midwife, who is specially trained to provide that care. The midwives have no direct access to that group of women and have been restricted to fragmentation of assessment, monitoring, provision of advice and support with centralised authority (Keirse et al 1989: 806, Robinson 1989: 162, Turnbull et al 1996). Hospital midwives became part of the obstetric team and the community midwife was in the danger of becoming a maternity nurse giving postnatal care only because of a very small number of home confinements in Scotland. The traditional clinical skills of the midwives were denied to the mother by the technology of birth and increasing specialisation. Their attention was focused primarily on the machinery and on the uterus to ensure that the uterus responds to machine delivered pharmaceutical stimulants. Midwives have to be instructed and proved themselves competent in the technique, machinery and epidural top-up in hospital environment.

Professional rivalry was not limited to the contest between the midwifery and medical professions (Tew 1990: 7). Some writers (Parboosingh et al 1989: 195) argue that

the increasing use of sophisticated obstetric technology was a defensive behaviour of obstetricians because they were exposed to cross-fire from their clients and colleagues. They have to face the constraints of the threat of litigation whenever a less than perfect outcome occurred and also ethical dilemmas in the case of ultrasound to detect abnormalities that have predictable but grave prognoses.

The qualified midwife is legally responsible for delivery of the baby and after care. The present maternity service discourages in a way already existing social patterns of mutual aid between women. The trained midwife competed with the 'handywoman', the woman's mother, the grandmother, neighbours and GP for the role of adviser and helper.

The approach of holism in midwifery can bridge and balance the disparities between the medical professionals and women because of the midwives' sensitivity and their historic interest in women's lives (Page 1988: 251-2). The ideas about what women and professionals wanted in term of maternity practice changed over time. What has remained constant and essential are the difference between women's perception and demands and medical preferences and priorities (Lewis 1990: 16).

5.3 Women's experience of childbearing

Women's experience of childbearing can be viewed through the changing demands from a safe childbirth to 'natural childbirth' (Dick-Read 1942), 'prepared birth' (Kitzinger 1990: 95 & 101, Snaith & Coxon 1969, Odent 1984), 'active birth' (Tew 1995: 187) and 'the women centre childbirth' (DoH 1993a: 5-7). Oakley (1981: 224) differentiates 'natural' from 'medical' childbirth, Kitzinger (1987) sees childbirth a 'fantasy' and 'art', Wagner (1994: 27-42) divided childbirth into 'social' and 'medical' model. A 'natural childbirth' has therefore given a new cultural meaning to human childbearing. In fact many critics are aware of the cultural configuration of childbirth (Snaith & Coxon 1969: 186-7, MacCormack 1982: vii, 2, Homans 1982, Kitzinger 1982, Odent 1984, 1990, Cosslett 1991: 221). Much of the intensified interest in childbirth is concerned with the increasing medicalisation of childbirth and proliferation of women's control over their body and the birthing process. Therefore, the 'natural childbirth' advocates in the past decades had not been aware of the fact that one can make choice only within certain situation in relation to the others in a wider context.

Many qualitative studies have been undertaken on the experience of women in the UK. Some in-depth studies were carried out by some sociologists (Oakley 1979, 1980,

1981, 1984, 1992a & b, Kitzinger 1984, McIntosh 1987, Green et al 1988, 1990) and midwives (Berg et al 1996: 11-15) and some are on specific aspects of pregnancy and childbirth (Woollett 1987, Woollett & Dosanjh-Matwala 1990, East & Colditz 1996: 93-97). Such studies demonstrate once again that women's experiences of care during childbearing are difficult to define and to measure in terms of preference, satisfaction, fulfilment, expectation and emotional well-being because women do not constitute a homogenous category. The evidence from some of these studies may be less reliable as every case is different in a different situation and at a different time. The distinct aspects may or may not inter-related.

The issues of control and autonomy (§1.4.2) are important for the women's well-being because they are generally linked to better emotional outcomes (Green et al 1988 & 1990, Mander 1993a & b, Campbell 1997: 4). Research undertaken on 68 women in Glasgow in 1982 confirmed some previous findings that there was some social class dimension to attitudes towards childbearing and its management (McIntosh 1989: 189 & 211-212). The middle class women looked for a pleasurable and rewarding positive experience based on ideally an absence of intervention and a co-operative relationship with their medical and midwifery attendants. The working class women were more concerned about painless and speedy delivery and had usually little opposition to intervention (McIntosh 1989: 210-212). But Green et al (1990) challenged this argument at a different place, different level and about half a decade later with the result that the women of lower social class have no lesser expectations than that of the middle class women from their study of 825 women. The women of different occupations in Green et al's study (1990) showed they were equally likely to subscribe to the ideal of being in control and avoiding drugs during labour. These attitudinal differences can be seen as a change over time with the development of science and ideologies.

The feelings of being in control and satisfaction were accelerated if the woman felt that she was seen as an individual, and to have a trusting relationship and to be supported and guided by the carers on her own terms (Berg et al 1996). The level of satisfaction was difficult to measure (Green et al 1990). Some women tended to express a high level of satisfaction if they have produced a healthy baby (Jacoby & Cartwright 1990: 240-241). They may not mind so much whether the outcome of their labour meets their expectation. The study above also indicates that the level of women's satisfaction decreased over time.

The move towards 'women centred care', within the discourse of health, has been widely supported by women's groups. The social support of the women is now widened

from the domestic sphere to the public sphere in a well organised manner. The pressure groups have helped to shape and change women's expectation and understanding of childbearing via their classes or media in accordance with social science developments. However some considerable differences exist between women and professionals in the meaning and practices of childbearing (Graham & Oakley 1981). Most women choose the mind and the professionals choose the human body to relate to their concerns or to define their experiences (Page et al 1997). The move towards women centred care is a government's tactic in the struggle of 'choice' and 'control' within all parties concerned (§1.4.2). It highlights the demand for changes in an organised manner in the political, professional and obstetric environment. This makes a contrast with Chinese women (Ch 3 & Ch 4), who enhance their experience of childbearing through the assistance from their kin's network and the manipulation of the balance of yin and yang in their daily activities.

As the society develops, women's views toward childbearing have undergone significant changes. High-technology investigations, treatments and hospitalisation for childbirth were, on the one hand, perceived to offer women greater technical possibilities to decide and make their choices and provide them with a 'sense of greater control and self-empowerment than they would have if left to 'traditional' method or 'nature' (Wajcman 1991: 71, Tew 1995: 71); and, on the other hand, the domination of technology the obstetric profession made have greater capacity to exert control over treatment and women's lives (Wajcman 1991: 61). The childbearing experience of women is further presented chronologically in terms of their choices, control and autonomy through the process of pregnancy, birth, neonatal care and postnatal periods in order to give a brief picture of how women feel about having a child with a normal pregnancy and childbirth in compliance with the maternity services available in Scotland.

5.3.1 Pregnancy experiences

For many women pregnancy was a time of fears and anxieties. They worried about the health of the unborn baby, about some aspects of antenatal care and labour. Their expectations focused upon the ending of their pregnancies as if the completion of their pregnant state became an end in itself rather than the beginning of their motherhood (Elbourne 1981: 133). Their reactions to pregnancy depended on the kind of relationship they had with their partner (Oakley 1979: 203). Although most of the pregnant women were pleased to be pregnant, some of them had mixed feelings, which may be related to the fact that many pregnancies were not planned.

Most women in Britain entering pregnancy can expect to receive at least one ultrasound scan either to confirm the period of gestation or to show the fetus is active if this is in doubt, especially if there has been a history of bleeding (MIDIRS 1996). The main argument surrounding routine scanning is if women like it or view it as threatening or as a test. In general pregnant women welcome this opportunity to see a moving image of their baby (Neilson 1995b). They have found it fascinating and reassuring to see their fetuses moving on the real-time display. The sight of fetus via technology has been brought on the issue of the prenatal mother-child relationship (Oakley 1984: 182, 4). Fetal visualisation also encourages women to decrease their smoking, restrict their alcohol intake, go to the dentist more and behave towards the fetus more responsibly (Oakley 1984: 185).

However ultrasound scan provides 'a window on the womb' (Oakley 1984: 156) to enable obstetricians to observe the fetus, to learn about normal fetal growth and detect deviations from normality under the professionals' control and surveillance in Foucault's term (1973, 1977). The sex of the fetus may also be able to be identified in the later stage of pregnancy. A small number of abnormalities will be identified either correctly so that relevant action can be taken at the appropriate time; or incorrectly, when some undesirable emotional distress and action may be imposed on the woman and her fetus (Tew 1995: 127-131). Although there is no compelling evidence that routine ultrasound will lead to a reduction in the overall perinatal mortality rate (Neilson 1995a) and change the overall pregnancy outcome of the population of low risk women (MIDIRS 1996), it certainly has changed the women's experience of pregnancy (Oakley 1984: 185).

Ultrasound scan has enable the women to see their own embryo or fetus from six week gestation onwards. This reinforces the separation between woman and fetus but also establishes a continuity between embryo and the birth of a child (Spencer et al 1998: 9) and facilitates the bonding between the mother and child. Women may feel the privacy and integrity of their bodies are threatened during pregnancy because ultrasound scan can yield so many new types of information about fetal private lives and expose them to medical scrutiny. Furthermore the ultrasound surveillance on the fetus may reinforce the mothers' reliance on the professional providers of maternity care and offer a potential access for the professionals to control over the women's bodies and the process of pregnancy and childbirth. It has also displaced some of the traditional reliance upon the women's own time of conception and the skills of clinical examination, e.g. pregnancy tests, abdominal palpation, etc. (Spencer et al 1998: 1, 9).

As pregnancies are subject to increasing surveillance and investigations, the chances for women to know the sex of their fetus have greatly increased. Unlike Chinese women (§ 3.1.5 & § 4.1.2), many Scottish mothers who have had an ultrasound scan or amniocentesis reject the idea of knowing the sex of their child as the information of the sex of the child may limit their mental exploration and imagination (Prince & Adams 1987: 82-83). They have expressed their wishes of having 'a surprise' at the birth of the child because birth is regarded as the first encounter and ends several months of speculation about the sex and appearance of the baby.

Biological sex is the first piece of information that is generally given on the delivery of a baby. The sex of the baby clearly matters (Wellings 1995). The results of a study carried out in a London hospital in the 1980s showed that first-time mothers of boys felt a greater sense of achievement than those who had given birth to a girl (Nicholson 1990: 69). The sexual identity of the fetus may or may not be the primary concern to Scottish people.

Most women experience some minor discomfort at some stage of pregnancy, for example, fatigue, aches and pains, backache, morning sickness, urinary frequency, Braxton Hick contractions, constipation, breathlessness and heartburn, haemorrhoids. They usually seek explanations, advice and reassurance from the professionals or from the self help groups. Although pregnancy is now generally not considered as an illness, it makes demands on the women physically and emotionally and calls for a review of their life style.

A reasonable amount of regular exercises is considered safe and beneficial for women. It improves blood circulation and emotional well-being, strengthens the muscles and relieves tension and facilitates an easier pregnancy and labour. A pregnant woman can go anywhere within reason and continue with sports to which she is usually accustomed for example, aerobic classes, horse riding etc. Swimming is a popular exercise for a pregnant woman in Britain.

Most women, especially primigravidae in Britain stop working around 28 weeks, assume a domestic role and remain ambivalent about their employment outside the home after their babies are born. Much effort has been made to advise pregnant women to look at their domestic and work environment to reduce or avoid stresses and strains inducing situation. They were expected to attend antenatal classes and antenatal clinics. Generally speaking, classes attracted mostly primigravidae or primiparae. Insufficient input of baby

care skills was identified and recommended to be taught postnatally (Nolan 1997: 25). The parents-to-be were and are guided by the health workers to realise their responsibility and the value of self-help and taught how to make the best of whatever resources they had (Lewis 1990: 19). They were expected to be able to identify ways of coping with the problems they were likely to meet in pregnancy, during and after their childbirth.

Women nowadays believe the quality rather the quantity of their diet counts. A well balanced diet of protein, fat, carbohydrate and minerals helps to maintain the maternal health and provides all of the nutrients essential for fetal growth and development. This concept of nutrition has penetrated the majority of the Scottish women's minds and formed a sharp contrast with the Chinese principles of hot and cold (§ 4.1.5).

Women are advised to avoid soft cheese, liver, 'convenience and instant' processed and packaged foods. Milk is often the first on the list for their diet. Many women take folic acid in their pregnancy because it is thought important to prevent spina bifida especially in the first 12 weeks. Diet advice to women during pregnancy was considered as exclusively of benefiting the unborn baby and ignored the mother's own preferences as if the women were a machine to make a baby and this may lead to woman blaming if there was a miscarriage or a premature or low birth weight birth (Kitzinger 1987: 40-54, 76).

5.3.2 Childbirth

Childbirth experience is presented through the discussion of birth plan, place of birth, support, position in labour, diet in labour, pain control in labour and obstetric technology.

Birth plans were introduced into Scotland in 1990s to facilitate women's choices of childbirth in where and how they give birth, who accompanies them and what analgesia they use (Kitzinger 1987: 150-171, Too 1996: 33). Having a birth plan is regarded by the expecting women as a means of exercising control and making choices over constraints. The arguments against it are the 'choice' a woman made is likely to be her obstetrician's choice; it can restrict a woman's choice so that choices which do not appear on the birth plan can be quietly and politely discouraged (Kitzinger 1987: 295); and it can intimidate some health workers (Kitzinger 1987: 150, 152-3) even though there is a dispute on this matter (Smoleniec & James 1992: 394-397).

The best available research evidence (MIDIRS 1997, DoH 1993a: 23-25, Mander 1993b, Kitzinger & Davis 1978) suggests that women are given little choice about place of birth. Over 98% of women in the UK gave birth in hospitals and about 2% had their home births either by choice or by chance in 1996 (MIDIRS 1997). In a survey of 1005 mothers 44% expressed their preference of Domino scheme and 22% indicated that they would like to consider a home birth (MORI 1993, NRPMSCG 1996, DoH 1993a, MIDIRS 1997). When the choice of place of birth is made, the decisions of the pattern of antenatal and postnatal care and the lead professionals such as obstetrician, GP or midwife are also taken (Campbell 1997: 4).

Hospital birth is promoted as a better choice for women though there is no clear statistical evidence suggest that home delivery is less safe for women with uncomplicated pregnancies (Tew 1995:2 & 10, MIDIRS 1997, Campbell 1997: 16). The rise of hospitalisation for childbirth has become an integral part of the birthing culture in Scotland and brought in for decades heated debates around whether it was the result of the safety of hospital or the choice of women.

Women were separated by hospitalisation for childbirth from their own social support network (Keirse et al 1989: 805 - 814). In order to improve women's birthing experience many new practices have been developed such as midwife-led units, normal delivery unit (Turnbell et al 1996, Hundley et al 1995, Walker et al 1995) to promote 'woman-centred care' (DoH 1993a) and 'one to one woman care' (Kitzinger 1996). Their focus of care shifted from the care of women to helping them to help themselves and enabling the women and their families to be in control of their pregnancies and the birth of their babies (Page et al 1997). These changing meanings and terminology reflect the changing patterns in women's needs with the development of midwifery technology and maternity care. They also reflect the changing meanings in women's perception of 'natural birth'. However, the demand for a change of place of birth continues to exist among some women.

Home birth re-emerged as a desirable option for some women in Britain. The option of domiciliary births at present reflects the professionals' response to meet the needs of women in their childbirth. A retrospective review of the outcome of 277 planned home births in a GP practice in London between 1977 and 1989 indicated that 215 women had normal births at home without needing any specialist help and postnatal complications were rare (Ford et al 1991). The review concludes that home birth is practical and safe for a self selected population of multiparous women but not for nulliparous women because they

may require transfer to hospital during labour. The issue of transfer is important when considering home births in this study. Another collaborative retrospective survey of 558,691 registered home births in the former Northern Regional Health Authority during 1981-1994 supported the argument that more women could almost certainly be delivered outside hospital with equal safety (NRPMSCG 1996).

Fourteen percent of 253 women in a survey (Davies et al 1996) expressed their wishes of having a home birth and were actively dissuaded by their carers. Thus women's suitability for home delivery actually rests on the recommendation and suggestion of the medical and midwifery professionals (Enkin 1995: 367, Oakley 1979, Donnison 1988) and their choice comes under question, if they 'do not really have the status of responsible individuals' (Stanworth 1987: 49).

The involvement of a supportive birth companion reflects a growing level of awareness by professionals and women of the limitation of hospitalisation and of the desire to make childbirth a positive experience for parents and infants (Odent: 1984, Keirse 1989: 807). Globally there have been 10 RCTs of social support during pregnancy with a population of more than 3000 (MIDIRS 1996). The results of these trials are consistent that social support is beneficial to most people.

The differences between social and professional support may not be rooted in the nature of the actions but in the nature of the relationship between caregiver and recipient and the meanings attached to the action (Hodnett & Osborn 1989: 182). Labour companionship from the same community was proved easier to communicate to and share the common value with the women in a study (Hofmeyr et al 1991: 756-764). Comfort, reassurance and praise were specific contributions a genuine companion made. The presence of a companion on a full-time basis conveyed a message of concern for and value of the women as individuals.

The recent systematic reviews of these trials showed that continuous support was associated with lower use of pharmacological analgesia, women were more likely to be breast feeding at six weeks and there were no negative outcomes associated with support in labour (Hodnett 1995, MIDIRS 1996). These reviews neglected some of the previous findings of 'the potential for territorial rivalries' between the professionals and the birth companion and a staggering increase in intervention rate and instrumental deliveries associated with the presence of the partner and/ or other birth companion (Keirse et al 1989: 813, 805). The element of cultural difference in acceptance of the presence of a non-

kin companion and/or certain supporting behaviour like touching requires further study, especially for Chinese women.

The research on the effect of maternal position in labour on outcome has not been thorough (MIDIRS 1996) and most of studies were conducted on the first stage of labour (Flynn et al 1978, Garcia et al 1986, Robert 1989: 883-892). Some were ethically questionable, which can be observed in Flynn's study of 68 women (1978). The radio telemetry was used to monitor fetal heart rate and intrauterine pressure continuously for an ambulant group of 34; and a fetal electrode and an intrauterine pressure catheter were used for another recumbent group of the same number. The women allocated to the recumbent group though expressing their interest in ambulation during labour were led to believe that there was no more telemetry machines available for them. The idea of this method is not to worry how the women feel about, but to be sure that the division of them into two groups is done independently of human choice. The findings were that ambulation seemed to shorten the labour, required less analgesia and the condition of the fetus during labour and babies at birth were better. Therefore the study concluded that ambulation in labour should be encouraged. The significance of this RCT test is very much dependent on the number in the groups. With a small number of 34 in each group it is easy to give the impression that ambulation is statistically significant and it may also be clinically difficult to exclude the possibility of the importance for an individual in many cases.

Most of the second stage trials (Sleep et al 1989: 1129-1144, Shannahan & Cottrell 1989, 1985: 89-92) have focused only on the use of birth chair. The available evidence (MIDIRS 1996) indicated that most people chose what they think is expected of them culturally and socially, and delivered their babies in a semi-recumbent position in the bed because all trials have taken place in a hospital setting. Birthing in bed made labour easier for doctors to manage and intervene, and it subjected women to inferiority, submission and weakness according to Tew (1995: 147-8). The experience and expectation of the midwives and doctors influence the range of positions they encourage women to adopt because some women rely on them to explore a range of possible options.

From the analysis above it showed the women are in need of the professionals' assistance in helping them to understand the implication of her autonomous decision (Jacoby & Cartwright 1990: 243) in their position of labour in order to improve the quality of their delivery and that of their child. The achievement of it has to be based on the willingness of the professionals to share or to negotiate their autonomy within their relationship. Women's autonomy in term of choices can only be realised through constant

'bargaining or negotiation' between the professionals and mothers (Rothmans 1986: 106-107, §1.4.2, §10.4.2). However two issues remain clear and constant, first, there is the limited choice of positions especially in hospital environment for the mothers and secondly, the professionals retained the ultimate sanction to what choices should be available to the women (Mander 1993a: 373-4, 1993b: 25). The choice of position in labour and delivery entails acquiring a certain degree of power (Kitzinger 1987: 295), autonomy and responsibility (Towler & Bramall 1986: 291-293).

The medical approach treats childbirth as a medical event. The general practice in the medical model tends to withhold food from women in labour. This practice is different from that of the lay Chinese (§4.2.4). The medical discouragement of food intake is based on the theory that should women need a general anaesthetic (GA), there is a danger of inhaling stomach contents (Mendelson syndrome) if a vomit or regurgitation occurs. The acid aspiration may cause chemical burns in the airways and result in disruption and necrosis of the bronchial, bronchiolar and alveolar lining (Chalmers et al 1989: 817, Enkin et al 1995: 202). Anyway many labouring women would not have a desire to eat during labour. If they do, it could be argued equally strongly that it is not sensible to deprive them of their source of energy when they need it most and put them at risk of ketosis² than the danger of inhaled material from gastric aspiration as most of them will not need surgical interventions. The practice of fasting all women in labour for an event of emergency may prolong their labour due to starvation and exhaustion. If they do need surgery, more and more of the procedures are performed under epidural or spinal block nowadays instead of GA. Thus the benefit of allowing the mother to eat and drink naturally may outweigh the potential hazards of the use of intravenous infusion of glucose fluid and other means of emptying stomach or neutralising gastric juices.

Labour pain has been acknowledged for centuries. The thought of the actual birth can sometimes perturb the woman into a state of uncertainty and anxiety, especially for primigravidae. When uncertainty and anxiety reach a climax, they turn into fear. Fear in turn produces tension in muscles and nerves and this tension results in pain and consequently delays the labour. This vicious circle of fear, tension and pain defined by Dick-Read (1942: 64) believed that pain could be relieved by explanation of the birth process and by women learning relaxation techniques. The women in Berg et al's study

² The condition in which ketones are formed in excess in the body, when fat metabolism is disturbed as a result of carbohydrate lack

(1996: 13) also experienced that if the guidance was too predominant, it could precipitate them into a state of fear, stress, aggression or disturbance. The contact with calm, sympathetic and supportive people during labour can be beneficial. Another more significant approach of pain perception is gate theory (Melzack and Wall 1988), which propounds that psychological factors as well as physical ones can affect pain perception.

To investigate the extent of pain and its management, the National Birthday Trust (NBT) mounted the first one-week national prospective survey on the pain relief in Childbirth of 10,352 women delivering in the UK in June 1990 (Chamberlain et al 1993a & b). The survey applied a unique method of fourway comparative analyses on the responses of the women, her partner, the midwives and doctors through postal questionnaires. The findings were presented by the researchers from different disciplines and different perspectives. They identified the major determinants of the use of pain relief are the method planned by the woman, the mode of onset and the duration of labour (Chamberlain et al 1993b: 115, Steer 1993b: 67). The methods of pain relief planned and used in labour were found to be personal choices modified by experience in a previous birth (Steer 1993b: 67). This again confirms Melzack & Wall's (1988: 20-1) experimental finding that the experience of pain is affected by previous experiences of how the women were taught and remembered the cause of the pain and its consequences.

The NBT 1990 survey has demonstrated that the method of analgesia planned had no significant correlation with the mode of delivery, although the mode of delivery had a highly significant correlation with the method of analgesia used (Chamberlain et al 1993b: 115). Steer (1993b: 67) found the choice of method of pain relief is affected only slightly by the sources of advice or environment, which is in the line with Murphy Black's finding (1990: 90) although the women required less analgesia during their childbirth. There is no convincing evidence to show the mothers who attended antenatal classes actually took less pharmacological pain relief (Tew 1995: 96). Many researchers agreed with the idea of social and cultural construction of experience of pain, personal choices and ethnic origin that had some effect on their choice and use of analgesia (Steer 1993b: 65, Snaith & Coxon 1969, Melzack & Wall 1988: 20-1).

Pain relief and coping with pain were identified in NBT 1990's survey to be two different issues for the women in labour (Wright 1993: 79). The methods of relaxation, breathing, distraction, massage and TENS were considered beneficial in coping with pain but not actual pain relieving techniques. The levels of labour pain were associated with the use of varying coping strategies according Niven's (1994: 110) study of 101 women in

two phases: obstetric factors and coping strategies in Scotland. Niven (1994: 112) suggested that personal or staff control were neither associated with significantly higher or significantly lower levels of pain though they would lead to a better experience of well-being (Green et al 1990). Personal control in labour means a different thing to different people. It is associated with the active application of coping strategies. The negative medicalisation of staff control was not apparent in Niven's study (1994: 114) in the forms of controlling the environment through access to expertise, analgesia and to their relatives but the positive attitude to staff control was clear in the form of 'trusting staff' in the co-operation with their advice and clinical decision.

The perception of general anaesthesia and epidural as effective methods of pain relief is much more common amongst the women themselves than among the professional staff (Steer 1993b: 50). The most common used forms of analgesia are entonox (60%), pethidine (37%), epidural (18%) and diamorphine (2.1%) (Steer 1993b: 49). According to CRAG (1996: 7) 37% of parturient women received the service of anaesthetists in 1996 in Scotland and 88% maternity units or hospitals provided 24-hour on demand epidural service in the labour ward/theatre service. The experience of severe pain in labour was found in the NBT's survey to remain an overwhelmingly common experience despite the use of analgesia (Steer 1993b: 67, Chamberlain et al 1993b: 116). The average intensity of labour pain rating was higher among the women than that of the midwives in Niven's study (1994: 101). People debated whether the pain comes mainly from fear, and thus from women's inability to relax and therefore increased their perception of pain (Snaith & Coxon 1969). The degree of labour pain is not only the simple sensation of the amount of uterine contraction pain. The perceptions and tolerance of pain of an individual are influenced by one's age, personality, maturity, previous experience, mental states (fear, anxiety), cultural learning, cultural expectations and the understanding of the situation (§4.2 & §8.2).

Oakley (1993b: 111) indicated the limitations of the analyses of the whole NBT 1990's survey, particularly with regards to the bias towards the hospital orientation of the questionnaires and some likely spurious significant associations generated by application of chi-squared tests of such a large number of tables in her postnatal follow-up to the questions asked of women six weeks after birth. Many associations statistically unrelated to either the satisfaction or the outcomes may well be meaningful and important to the women in real life particularly in the examples of partner's support, and the woman's social context. Over one third of the women changed the response to the questions on the

experiences of labour pain after delivery and at six weeks with an increase in their negative feeling in terms of freedom of choice, information and side effects, or due to a feeling of failure and loss of control (Oakley 1993b: 105-106, Chamberlain et al 1993b: 116). This is not only a lapse of memory but also the changing experiences, perceptions and expectations over time.

Clinical surveillance and monitoring physical changes are ways of detecting complications during the use of a range of obstetric technologies in labour. The rate of intermittent CTG monitoring has reached 100% nowadays, despite the fact that routine CTG has never been shown to improve birth outcome (Jordan 1993: 155) or to lead to any substantive benefits for the baby (Enkin et al 1995: 211). The medical technologies take control over the process of childbirth in the forms of the use of analgesia, intravenous fluids, syntocinon, amniotomy, induction of labour, forceps delivery and so on. Women expressed once again that they wanted to be informed and guided on their own terms (DoH 1993a & b), Berg et al 1996: 14) in their decisions of acceptance of intervention of technology, although there is no straightforward measurement to tell whether the choice is informed or not and further more there is possible tension between the woman's choice and the professional clinical assessment and judgement.

Doctors' enthusiasm of being 'scientific' can appear obsessive. The medical professionals monitor the progress of labour at a constant rate. 'Partograph' designed by E. Friedman for clinical use in 1955, was used to allow obstetric and midwifery staff to determine whether an ideal progress was achieved. Any lag behind the ideal prescribed curve could be adjusted by increasing maternal mobility, artificial rupture of membrane, or intravenous infusion of syntocinon. The female reproductive organ of uterus and cervix were thus treated as a birth machine, that had to function at precision according to Adams (1994: 51-62).

The reality of the regular painful contractions at an early stage of labour may not be recognised by medical staff as 'true' labour until the cervix is three centimetres dilated. On the one hand the professionals rely on their knowledge, expertise and authority and on the other hand, the woman has her physical reality of 'painful labour pain'. If the woman appears distressed, it may lead the medical professionals to think that something may be happening and admit her to hospital for observation. If she gave birth to her baby ten hour's later, she would have had more than 10 hours labour. If she did not appear distressed, she would stay at home and go to hospital later. In that case she would have had less than 10 hours short or quick labour. Long or short, slow or quick labour these are

purely obstetric definitions. To this woman the fact was that she had labour pain for definitely more than 10 hours. Nothing could change this fact. The obstetric construction of the length of labour is problematic; it denies the woman's perception of labour. The denial of the belief of her reality leads to a medically dominated delivery (Rothman 1986: 107). Women are persuaded not to push before the cervix fully dilated. The diagnosis of full cervical dilatation is usually made by an internal vaginal examination after the presence of the woman's involuntary urge to push, rupture of the membrane, appearance of show of blood and/ or congestion of the vulva or the presenting part.

In order to fully utilise maternal effort directed pushing is usually 'organised' by the midwife in hospitals during the second stage of labour. Midwives assist and guide the woman to give ideally three big pushes during each contraction and rest in-between. They actively regulate the length and strength of the woman's pushing effort in an attempt to control the delivery of the fetal head and prevent a perineal tear. They become accustomed to deprive women of their control over their labour.

5.3.3 Postnatal care

The needs of postnatal rest have varied greatly from time to time. 28 days post delivery 'lying in' period in the mid-eighteenth century has been shortened to no more than one to two days nowadays (Enkin 1995: 345, Rush et al 1989: 1341). The length of stay for mothers in the UK in a postnatal ward is usually discussed and agreed between the woman, midwife and other professionals (DoH 1993a: 32). They are normally discharged from hospital after periods ranged from 6 hours to a week following an uncomplicated childbirth with an average of 2 to 3 days. The mothers are encouraged to become mobile as soon as they can tolerate it. This forms a sharp contrast with the postnatal practices and beliefs with the Chinese women (§4.3.1, §9.1).

After delivery women in hospital acquire two antagonistic roles at the same time: 'patient' role and motherhood role. The sick role is considered passive and leads to frustration and tension because the mothers and babies are nursed in a manner and a medical environment for the sick patients both in the hospital and at home. They have to have their daily temperature, pulse, blood pressure, postnatal checks and baby checks done. Regardless of the length of her hospital stay the women are usually visited by a community midwife daily or every other day as their needs indicate for a minimum of ten days after delivery. On the tenth day the midwife hands over her responsibility to the health visitor for continuing care of the baby. Sometimes the midwife may go on visiting the new

mother for as long as 28 days after delivery if she thinks that to be necessary. When the midwife has some concerns about the mother or the baby she would normally call the GP. The mother and the baby are advised to have a postnatal check-up with her own doctor at a clinic at six weeks postnatally.

The motherhood role is considered fundamental to the woman's self concept. When women's expectations and needs were not fully met women were noted as having baby blues or postnatal depression. 10-15% of women suffer postnatal depression (Cox 1986b) and 50-66% experience postnatal baby blues (DoH 1993a: 33), although there is no persuasive biochemical and psychoanalytic evidence (Romito 1989) to support the traditional medical explanations of the cause of postnatal depression. Romito (1989) suggested that there many predisposing factors leading to postnatal depression are deeply rooted in society's expectations of the new mothers and the solutions lie mainly in social change.

A qualitative study of 44 primiparous women (Laryea 1989: 182-183) indicated that there was a difference in the meaning of motherhood between the midwives and the mothers. Midwives used and emphasised the biological, medical and neglect social aspects of motherhood. They viewed it as a normal process in a woman's life cycle. Their emphasis was on physical aspects of looking after the infant and mother. The mothers viewed motherhood as an acquisition of a new social role, which gave them a senior status, a sense of belonging, feeling of recognition and a boost to their self-image and confidence.

There is little literature on postnatal dietary advice for the mothers. The normal dietary habits of the women usually resume after delivery. Some modification of diet may take place when the new-born has vomiting or diarrhoea. Much more maternal attention and efforts are drawn to breast feeding promotion, neonatal care and bonding development of the mother and the baby. This constitutes a marked difference from that of the Chinese (§4.3.2, §9.5).

5.3.4 Neonatal care

Problems with feeding were a major topic of discussion for some especially first-time mothers (Woollett & Dosanjh-Matwala 1990). Breast feeding has been encouraged, supported and promoted since 1980s. Many voluntary breast feeding organisations or

breast feeding counsellors offer sympathetic advice and support to the breast feeding women.

The ideas of how to provide the best care for the new-borns are changing with the development of human knowledge. The arguments put forward in favour of breastfeeding concentrated on the belief that the mother's own milk was the best food for the child and the desirable emotional bonding between mother and the infant which resulted from suckling, direct eye and skin contact (RCM 1991, HEBS 1995, 1997). Research evidences suggest breastfeeding reduces risk of mortality in preterm infants from neo-natal necrotising enterocolitis, childhood diabetes, reduced morbidity from gastro-intestinal infections, respiratory infections, urinary tract infections etc. The baby will benefit even if s/he is breast fed for a few weeks, even days (HEBS 1995, 1997).

The arguments put forward in favour of artificial feeding blamed breast feeding for interruption of the mothers' social life or spoiled their figures (RCM 1991: xv). Artificial feeding was perceived as a success of the modern science and technology and thought a convenient choice because of cheap and/ or free dried cows' milk from the welfare state (RCM 1991: xvi).

Mothers are usually helped by midwives with breast feeding or bottle feeding according to the mother's preference. They are encouraged to feed their babies on demand. They normally receive a package of information on winding babies, nappy changes, washing, bathing babies and maintaining a healthy and safe environment for babies.

5.4 Summary

The first section of this chapter tries to bring out the social context for the women in Scotland. This includes women's role, social status, employment pattern, migration and effect on kinship in term of availability of support and control. There are two general features in Scottish society in comparison with that in China: a greater proportion of urban population and less evidence of ancient, traditional or gender practices.

The second section of this chapter focuses on the maternity care, its medical philosophy and the inter occupational rivalries in childbearing with particular reference to the childbearing in Scotland in order to help the understanding of the implications and impact of different systems or ideas on the experiences of women discussed in Chapters 7, 8, and 9.

Medicalisation of childbirth is part of the culture in Scotland. There are four major forces in the culture of Scottish childbearing. First women demand active control of their body and their childbearing experience. These are part of the contemporary Scottish social and cultural background and beliefs. Second, in Scotland today, there are women's support groups to produce the strategies of resistance against any policy which they consider inadequate and to produce social pressure for changes in favour of what they think are good for women. Third, the female-dominated midwifery services have assumed that they will guard the rights and interests of women and be able to give more holistic and empathetic style of care in normal childbearing. Fourth, the medically oriented Government policy of childbearing sets ideas of research and drives the research agenda in theory if not in practice. It leads to the rise of hospitalisation for childbirth and consequently, the demand for 'women centred care'.

The final section concentrates on the cultural and ideological dimensions of the women's experience of maternity care in Scotland; the social pressures for them to regard motherhood as the fulfilment of their lives; and the fact that women's experience of childbearing is dependent upon their social circumstances, their health status and the meaning derived from their ethnic and social class culture. The feeling of being in control is linked to a better emotional outcome. The rhetoric of the woman centred paradigm is trying to recognise the women's defining role of the appropriateness of birthing technology and reclaiming women's positive feeling in their childbirth. It emphasises the value of self-help and responsibility in the event of childbearing. The rhetoric of the medical paradigm assumes that childbearing requires a series of medical surveillance, monitoring and a reliance on technology especially during labour. Different world views thus generate different professional approaches.

On the whole this chapter sets the scene how a normal childbearing process is likely to be in Scotland within a set of historical and social conditions. It addresses the relationship and different orientations of obstetricians, midwives and women in Britain on the issue of choice and control, provides a baseline which indicates how a woman in Scotland would experience normal childbearing and argues that the women's experience in Scotland is different from that of Chinese women described in Chapters 3 and 4.

Chapter 6

The Chinese in Britain

Following the analysis of the Chinese and Scottish social, cultural and medical background, this chapter is intended to pull the threads from Chapters 3, 4 and 5 together to show what happens when Chinese people from the context outlined in Chapters 3 and 4 are in the context in which the British medical organisation and ideas prevail. This is also to explore to what extent the history of the Chinese immigration and settlement patterns in the UK might explain some findings relating to this study in terms of occupation, sense of identity, ethnicity, perception of health status, childbearing and childbirth. Much of the literature on these topics is limited in scope and it remains a relatively neglected topic. These themes are analysed and presented in five sections: 1) background to Chinese migration, 2) settlement in the UK, 3) Chinese people's lives in Britain, 4) racism in Britain, 5) The NHS and ethnic minorities.

6.1 Background to Chinese migration¹

Chinese public opinion has been against living abroad according to Purcell (1951: 33 & 37-8, 1967: 8) and in my personal experience. In the first place, most people take seriously the Confucian teaching that a good son never leaves home while his parents are alive. Secondly, the belief of ancestor worship, although this is not unique to the Chinese, discourages people from emigrating, because the spirit of the dead needs the constant attendance of the living to ensure their welfare. Those ancestor spirits left without sacrificed offerings and ritual attendance will disturb the peaceful life of the living. Thirdly, it is difficult to leave one's community with all the relationships and values to which one has been born and face life in another society with a different language, a different set of social values and a different cultural heritage.

Despite these feelings there was substantial emigration to Southeast Asia, Britain, the USA, Canada and Australia in the 19th and 20th centuries as the result of

¹ The synthesis of the existing knowledge about Chinese immigrants in the UK is obtained from data from this study, personal observations and contacts, state census and researches, which provide the basis for further analysis and interpretation of social life, health status and health seeking behaviour.

the 'push and pull' phenomenon (Watson 1975, Lee 1960) of the difficult political and economic situation at home and the need for cheap labourers overseas (Seward 1970, Barth 1964, Purcell 1951 & 1967: 6, Alexander 1973, Hodder 1996, Willmott 1970, Tsai 1986: 3). The early Chinese migrants were mainly from three coastal provinces of Guangdong, Fujian and Guangxi simply because the first European effort to trade were centred in Guangdong Province (Tsai 1986: 3, Barth 1964: 50, Purcell 1967: 1). Most of the Chinese, as with many other migrants, migrated with the intent of a short stay and a desire to return better off (Chan 1980: 33-34).

There are four distinct phases in the general profile of Chinese migration to Britain. First, the earliest migrants in the early 19 century were seamen employed on British merchant ships (Ng 1968: 5, May 1978, Baker 1981: 5, Li 1992: 105, Cheng 1996: 163). Most of the first group of migrants set up and worked in laundries and later moved into catering, retail businesses, such as vegetable growing, market retailing, Chinese food processing, which peaked after World War II (Ng 1968, Watson 1975, 1977: 181-213, Schott & Henley 1996: 257). The second phase was in the early 1950s, during which period mainly professionals came as the result of political upheavals in China (Schott & Henley 1996: 257). The third phase was in the early 1960s when people from Hong Kong and New Territories came as the result of the collapse of agriculture in the New Territories; 75-80 percent of the Chinese population in Britain nowadays are a result of this phase (Li 1992: 105-6). The fourth phase (Haskey 1997: 20 & 22) for the entry of ethnic Chinese came as the result of the entry of the 'Boat People' from Vietnam since 1980s (Schott & Henley 1996: 257) and increasing numbers of the postgraduate students and scholars from Southeast Asia, mainland China and Hong Kong prior to and after Hong Kong's hand-over to mainland China in 1997.

6.2 Settlement in the UK

The Chinese population in the UK has been reported as 156,938 (male 77,669 and female 79,269) and forms 0.28 percent of the UK population according to the 1991 Census, 'the first to include a question on ethnic groups' (Haskey 1997: 13). This ethnic group is small in size, balanced in gender (Cheng 1996: 161-178) and expands more quickly than the host people because it consists of more women of childbearing age.

The total Chinese population in England was 141,661; Scotland, 10,476; Wales, 4,801 (OPCS 1994: 148). The Chinese communities in Britain are considerably more dispersed than the other minority ethnic groups, even though over

90% Chinese population settled in England and 51% of them live in metropolitan areas (CRE 1987 & 1988, Ng 1968 & 1993, Watson 1975 & 1977, May 1978, Roper 1988: 4-5, Chan 1988: 8, Li 1992: 105-116, Cheng 1994 & 1996, Schott & Henley 1996: 257, Modood et al 1997). This may be attributed to the early urban settlement pattern of the 19th century and the satisfaction of the psychological, social and economic needs of the early settlers in attempting to adjust to a new and strange environment. The China towns in London, Manchester and Liverpool offered mutual aid, a cultural environment and protection which the other areas in the country could not.

Scotland attracted about 6.68% of the Chinese population in Britain (OPCS 1994: 148). The settlement pattern in Scotland is generally similar to those in the other parts of Britain with regard to their occupations, gender differences, English language, housing, careers and use of social and health services (CRE 1987, 1988, Li 1988: 12) but their settlement are relatively recent and more highly concentrated in urban areas. Most of the families did not arrive before 1960s (Ng 1988: 18).

According to the 1991 Census, of the Chinese adult population over 18 years old, 11,812 were born in Britain and 103,377 outside Britain; in other words, about 88.6% of the Chinese adult population were born outside Britain and 21.4% were born in Britain. This percentage may not necessarily be same for some geographic areas such as London or other cities with established 'China towns'. The most up-to-date picture of the structure of the Chinese communities in Britain can be found in the *Labour Force Surveys of the Office of Population Census and Statistics*. They publish each year the changes of the size, composition and distribution of the communities. However, little is known about the daily lives of these people. This hampers our understanding of the different experiences of migration of different groups of Chinese and especially the childbearing experiences of Chinese women.

The Chinese in the UK consist of different groups of people: the descendants of the early migrants of seamen, laundry men, the later comers of catering workers from Hong Kong, the New Territories, Taiwan, Malaysia, Singapore and recently from Vietnam and mainland China (Ng 1968: 29, 31, Watson 1975: 104-106 Honey 1981: 15-19). The majority of recent new comers from Taiwan and mainland China are considered to be from relatively higher socio-economic positions (Cheng 1996: 179). They entered this country as students and scholars. Many stayed on after completion of their education or research projects. Though this group is small, it comprises the most highly qualified Chinese Britain has ever received, and can be

expected to impact on the socio-economic composition of the Chinese community in Britain in due course (Cheng 1996: 164).

People from Taiwan, mainland China, Malaysia and Singapore speak mainly Mandarin, the official language. Modood's study based on the 1991 Census and the 1994 Survey (Modood et al 1997, Modood 1997c: 321) suggests that 66% of the Chinese speak Cantonese, 10% Mandarin, 11% Hakka and the rest speak other languages or dialects. People from different areas may find it difficult or impossible to talk to someone from another part of the country. Yet the speakers of all languages have all learned a single written form of Chinese language and are able to communicate freely through writing, if they are literate in Chinese characters. The script of this language represents a cultural unity and a strong sense of 'Chineseness', which is based on traditional family relationships between senior and junior generations, male and female (§3.1).

The diversity of social origins requires further systematic study, especially in terms of occupation, education, psychological make-up before and after their migration and their associations with fishing, farming and the catering trade. There are four main categories of them in the United Kingdom according to their intention of stay and their occupations. They are the sojourners (Watson 1975, Lee 1960: 69-85), the established business people and professionals, the students and visiting scholars, and British Chinese.

A sojourner (Lee 1960: 69-85, Purcell 1965: 29, Watson 1975, Chan 1980: 33-42) is a person who clings to one's cultural heritage and intends to stay temporarily. The feeling of belonging is to the Chinese village where one was born and reared. S/he may have spent a large part of a lifetime working abroad for economic betterment, but the life object of full enjoyment and final achievement is in his or her hometown. Many sojourners were non-English-speaking workers, who arrived recently and are economically disadvantaged. They were seamen, laundry men in earlier times, and now are catering workers, shop assistants, waiters and waitresses. They live a relatively simple life and make little effort to make British friends and change their way of living. They reduce their present needs to a minimum in order to save for their future retirement of living in their homeland (Watson 1977: 193-4). The alienation they experienced as the result of institutional racism and immigration control reinforces the attitude of the sojourners.

The established business people and professionals are property owners, business proprietors, business executives and established well-settled professionals.

Most of them are well-educated urban people from Taiwan, Hong Kong and mainland China. They form a separate and distinct group in the British overseas Chinese community (Watson 1977: 195). They distinguish themselves from the other Chinese in the UK and have as little contact with the different groups as possible. They are more westernised, better integrated into the dominant society and assimilate selectively.

The students and visiting scholars are a dynamic group. They constitute a small percentage of the Chinese population in the UK. There are three groups of them. The first group believe their further study is to prepare them for a more important and a more promising mission at home and they have as strong a sense of pride and responsibility for the future of China. The second group began to study here and prolonged their stay in order to secure a free entry to Britain and then to work in their native land and serve their people. The third group have decided to use their expertise to obtain a job somewhere outside the place they originally came from to settle down and assimilate by application either of their academic or professional expertise or by a marriage to a native or a British Chinese. The students and visiting scholars are at a transitional period. Most of them came voluntarily in large number after 1980's. To ensure a high return rate, China's strategy was to channel fewer people to the United States of America (Zweig & Chen 1995: 82). The Chinese governments in Beijing and Taipei were confident that the British high unemployment rate would ensure that more students would return after the completion of their studies.

It is believed that the majority of the students came from the higher socio-economic strata (Zweig & Chen 1995, Lee 1960: 98). Most of them were nurtured and educated in an urbanised setting, for example, Taipei, Hong Kong, Beijing, Shanghai, etc., had achieved a certain degree of western knowledge and language skills before arrival and had the proper contacts for effecting their exit and entry. They exhibit characteristics of 'cultural pluralism' (Tsai 1986: 124) and a high degree of individualism and economic motivation. They are expected to return home after study or work. Their social and occupational upward mobility is more rapid on their return home. But some of them are attracted to Britain's metropolitan areas, partially due to the employment opportunities and partially due to the presence of Chinese communities. They have become teachers of Chinese, Chinese history, Chinese medicine, acupuncture and computer scientists in the colleges or universities and others have secured responsible positions in research laboratories or other occupations in the UK. They have the same experience as 'sojourners' living temporarily in a

strange land under strict institutional and social restrictions and needing to meet specific work objectives within a limited period of time (Cox 1986c: 76).

The British Chinese comprise citizens of the United Kingdom by virtue of naturalisation and those who are born into those families within the UK. They may have been in the UK for several generations. They are called British Chinese or Chinese British. These two compound noun phrases are felt differently by them in my view, though many may not be able to tell why. 'Chinese British' postulates the actor is a British person of Chinese origin. The pre modifier: 'Chinese' defines the essential functional properties of this specific actor (Halliday 1985) and gives a structural priority and the reference of the head word. The semantic meaning of the phrase indicates that the speaker considers the person Chinese before British and implies that s/he is different, and therefore s/he is not entitled to enjoy full rights and privileges. The expression 'British Chinese' is an attempt to correct this distorted social relationship between the ethnic minority and dominant groups.

Chinese integration proceeds in a different way from that of the other British ethnic minorities, from, for example, the Indians, with whom the British had a closer colonial relation culturally and politically though socially they may still separated. This sometimes makes the Chinese seem less mixed with the host population, but this is not entirely the case. The 1994 Survey suggested that more than a third of the Chinese population had a higher British qualification. They were much better qualified than whites and other minorities in term of educational qualifications (Modood 1997a: 64).

Approximately 90 percent of the Chinese work force were engaged in the catering business according to Li (1992: 106) and a third of the work force were self-employed (Modood 1997b: 122). The phenomenon of their employment or self-employment is the reflection of their economic opportunities, racial disadvantage and cultural values (Berthoud et al 1997: 9). The number of professionals was small though growing, perhaps two to three percent (Li 1992: 106). The majority of skilled and well educated workers were working below their capabilities or reduced to work as unskilled labourers (CRE 1988). They have become the victims of this downward social mobility. Some critics argued (Cheng 1996: 178-9) that quite a large number of the well educated had been more successful in getting into top occupational groups, even though they might not necessarily be in the most desirable top jobs. However, Modood's findings (1997b: 145, 1997d: 341 & 346) gave a more comprehensive picture that two-third of the Chinese men were in non-manual work even though they were seriously under-represented as managers and employers in large establishments. They appeared less likely to be employees in higher or intermediate non-manual work

than British-born white people but more successful than other non-white groups. Nevertheless their high qualifications effectively masked their difficulty in gaining access to desirable jobs. They still fell far short of work appropriate to their qualifications.

According to Modood (1997b: 104) 76 percent of Chinese women in the work force were in non-manual work. They were more likely to be professional workers. The overwhelming majority of women in skilled manual work were self-employed. They tended to be part-time workers either because of family commitment or some direct discrimination.

6.3 Chinese people's lives in Britain

This section first focuses on individuals' lives and experiences then family and kinship networks beyond the household, and finally the community in order to indicate how Chinese people have coped with and managed to create their 'traditions' and 'heritage' in this new country. The measures of their lives in Britain are based on their sense of distinctive identity and ethnicity through discussion of their preconceptions, experiences, language, religion and their social and cultural attitudes and activities.

Life in Britain often forces Chinese people to examine their preconceptions and to adopt both social and economic roles which may have been rejected at home according to literature available (CRE 1987, 1988) and my observation. This may involve some fundamental changes and dilemmas as the integration in this new environment demands adjustments in their relationships domestically and outside the household. In general it can be frustrating for the Chinese to find out that the set of rules or norms they learnt before migration is unsuitable for the industrialised and competitive society. Many start to feel inadequate, disappointed at being unable to express themselves, unable to communicate and unable to participate more fully as important members of the new society (Li 1992, Ng 1968, Watson 1975 & 1977). It may take many years for them to re-establish their previous status, prestige and wealth, if they come from upper middle classes.

They have to learn new customs, new behaviour patterns, new social codes and norms to cope with the situation. Inability in acquiring these social skills causes them to confront a crisis of personal disorganisation. They have to meet two sets of expectations in their social life: social expectations and individual fulfilment or satisfactions. If they are unable to play their roles well, they may suffer from inner

conflicts, feelings of guilt and failure. In self-defence they may resort to more defiant behaviour, which only generates more frustration and anxieties (Lee 1960: 325).

Many people attempt to reconstruct what was familiar to them to cope with the changes and challenges. The process of reconstruction of their past experience becomes an important source of their conception of selves, part of their knowledge, their comfort and refuge, their conception of their own character and potentialities (Buijs 1993:3). The memories of what they were familiar with in the homeland often rekindled a desire to remake their old way of life. This becomes their struggle to recover their cultural continuity and control or in other words their effort at 'invention of tradition' (Hobsbawm 1983: 1-14, Hobsbawm & Ranger 1983, Dirks et al 1994), a new meaningful identity² in the context of life in this alien environment.

Having lived in Scotland for more than ten years as one of the Chinese born outside Britain, the author shares many similar feelings with the local Chinese. As a person in a new cultural environment, one tends to be more aware of one's cultural traits, both physically and metaphysically, for example, physically: skin colour, clothes, food and eating habit; metaphysically, like language, way of thinking, behaviour, religion, customs, family structure, business organisations and recreations. One tends to be prompted by one's ethnocentric awareness to claim one's own identity in order to maintain one's inner balance, one's pride and cultural continuity. People prefer being left to work out for themselves a consciousness and mode of behaviour appropriate to their condition.

The physical features are taken by many other people as the obvious and convenient label for all differences in culture (Bowler 1993: 175). In Britain the physical features of the Chinese tend to be associated with the catering industry. Many of them are known either as cooks or restaurateurs. In Barth's terms (1969a: 38) the Chinese cultural 'continuity' after their immigration is thus maintained by the 'persistence' of these different physical features and 'maintenance' of this occupational boundary. This cultural trait is challenged by Cheng (1996: 178-9), who reported that it was true for only 40 percent of the working population and mainly characteristic of the Hong Kong-born Chinese. What is neglected in this debate are the continuous cultural changes that occurred in the process of integration of the Chinese in the UK. Chinese culture in Britain has been transformed into a culture with its own

2 Identity is an individual psychological reality of oneself or a group of people. Identity formation was an intra-psychic process that was located in the core of the individual and yet also in the core of his communal culture (Epstein 1978: 5-7, Barth 1969b: 10-11). Therefore ego-identity was achieved through a psycho-social process.

characteristics in the British context. The 1994 Survey (Modood 1997a & 1997b) suggested that the Chinese had higher British qualifications than other ethnic groups including the British. The image of the Chinese has thus been changing and already expanded beyond catering in relation to the change in their circumstances and environment.

The new well educated Chinese helped to heighten Chinese pride and changed people's perception gradually. They are fluent in English, work and socialise with the natives, and show more interest in public affairs; but, contrary to Tsai's observation (1986: 124) in the USA, the people of this category in the UK rarely socialise with the Chinese in catering and the shop trade. They have to confront an issue of their identity not only within an international context but also among their own people in relation to their own personal political viewpoints toward events taking place in their homeland. They generally maintain their Chinese heritage in their own way while selectively adopting the dominant culture.

A crisis of identity for some Chinese individuals is emerging over time even though they try hard to maintain their own cultural identities. Some of them may be surprised to discover themselves as strangers even among their own country people. Gradually those subtle changes come to be in the spotlight during their return visits or the interactions despite regular family contacts or other means of liaison mentioned by Watson (1975: 132-165) and Ng (1968). They cannot help questioning their own cultural construction of reality. The sense of loss tends to increase in strength. They may feel that they are neither members of the host country, nor the Chinese they claim to be. They are amazed to discover another reality that they belong to neither of the two cultures. The level of this self-awareness depends on the person's social position and his/her education level. The Chinese population in the UK is diversified and increasingly individualised. In general many of them gradually come to some new meanings and identities from the contradictions between present and past.

The Chinese family is the economic unit for analysis (Modood 1997d: 349, Chan 1988: 47). It has always been the most intimate and important unit in Chinese life. The conduct of a Chinese person is regulated by the codes of the family, which imbue one with the sentiments proper to a morality and traditional practices. The importance of the family is shown in the order of Chinese names. The family name or surname always comes traditionally before an individual's name. During a quick exchange of surnames among strangers, the identification of kinship is instantly established (Lee 1960: 135). The order of an individual's name is also a hint for the interpretation of one's level of integration and sense of nationalism. Traditional

Chinese prefer their surname to precede their own name to indicate their interest in Chinese tradition and their original ancestors. An individual is not important in a Chinese context. He or she is the medium of transmission of the family line and is trained to respect the paternal authority of the family and observe the interests of the clan. The westernised Chinese prefer their given name first to their family name to show their westernisation and their individualism symbolically. In addition to this, some people adopt an additional, western name as a school requirement or as a personal preference.

In terms of marital status, the results from the 1991 Census in the UK (Haskey 1997: 27) have shown that 85% of Chinese households consist of married couples with or without dependent children. In terms of family structures, the Chinese family patterns can be further broken down into five types: 1) nuclear family, that is a couple with or without children staying together as an economic unit; 2) broken stem family, in which husband, wife and children live separately in different countries because of immigration control; 3) grafted family in which the Chinese man has a wife at home and takes another wife or partner in the new settled country; 4) mixed marriage family refers to the family comprising a non-Chinese partner through marriage and 5) extended family consists of parents, children and other relatives, i.e. grandparents or uncles and aunts.

Gender has played a significant role in determining a person's position in British society in addition to race. Modood (1997b: 104, 1997d: 345) contends that Chinese women are nearly twice as likely as white women to be professionals, managers and employers. This may partially be correlated with the success in self-employment. However, Chinese women, in my observation, have not only to play their women's role as prescribed by Chinese traditions but also share the burden of making a living in the new environment. They have to work to help support their families especially when their husbands are unable to find a job or to support their families fully. Some are compelled to take up some poorly paid domestic work or various kinds of unskilled work that local women are not willing to accept.

Entering the job market meant acquiring some new skills for Chinese women, for example, learning the new language, some social skills, driving a car and earning an income. These skills increase women's self confidence and some of them gradually become more assertive, believing that they have a greater role in supporting their families and expecting a greater share in decision making on family matters. Chinese men, in my experience and observations, may feel humiliated that their authority as the head of the family is damaged in such situations because they have to

rely on their wives' income to support their families. The altered social role between men and women challenges traditional masculine authority and may often lead to considerable marital stress. The adaptation to life for the Chinese in Britain remains an ideological conflict with respect to traditional expectations.

Chinese values, norms and ethnic consciousness (§3.1) remain strong in most women's lives as many of them do not know English and cannot communicate with British people. Their roles of nurturing their children and maintaining the home are influenced by the lack of support from their extended family and friends of their own community (Leung 1988: 33-44). Chinese culture becomes the major means for them by which they receive, organise, rationalise, situate and understand themselves and their particular experiences in the world. They are reluctant to publicise their problems and attempt to solve them with outside assistance and many seem unaware of the social, political and economic demands of the larger society (Tsai 1986).

The better educated Chinese women, based on my experience and observations, conform to what the British have defined as appropriate types of partnerships for the creation of family and childbearing and childrearing structures. Therefore the ideologies of three obediences (§ 3.1.1) are challenged by them in the UK. They discover and appreciate the concept of marriage which is based on love without parental arrangement. They opt to postpone childbearing, have fewer children and seek to achieve financial independence. They try to alter the roles into which Chinese traditions had cast them, roles that they believed demeaned their status and confused their identity.

The Chinese population in Britain has been grouped on the basis of their languages, education, origin and intention of stay (Watson 1975, 1977, Ng 1968, 1993, Cheng 1996). They can also be divided into three groups, in my view, according to their political orientations, pro-Beijing group, neutral group and a pro-Taiwan group with the existence of two governments, the People's Republic of China and National Republic of China. There is a subdivision within pro-Beijing and pro-Taiwan groups. The first splits into two, for or against democracy and the latter, a pro-Guomindang (National Party) faction and a pro-Taiwan Independence Movement. Most Chinese in Britain do not agree with the 'communist' political system in mainland China but they feel proud of what has been achieved. They maintain a strong tie with their natal villages and therefore many of them are sympathetic to what has happened in China. The professionals and academic staff are divided according to their origins. The majority of the Chinese in Britain remain politically neutral. The identity

of a Chinese is fluid and is shaped by changing circumstances, the political environment at home and British cultural context.

Although more than half the Chinese people in Britain (Modood 1997c: 298) are not religious in a formal sense, they are at the same time either Confucianist, Taoist, Buddhist or Christian. Religion probably means to them a system of beliefs and a set of moral principles. Confucianism is more ethical than religious, while Taoism has become both ethical and religious. Therefore the Chinese have a choice between two ethical systems (Confucianism and Taoism) and two religious systems (Taoism and Buddhism). However Buddhism and Taoism have lost ground to the younger generations because of their mysterious aspects of teaching. Normally people just select what is meaningful to them. Ancestor worship is an example of this multi-belief, which is the most important, significant and real national religion for most of them to maintain the solidarity of the family and clan, and to protect them against the abuse of the principle of local and state morality (Granet 1975: 154, Ng 1959: 65-66, Baker 1981: 5). Among the well educated, this religious feeling manifested by Confucianism displays itself in an inner effort of personal cultivation along the line taken by national tradition (Granet 1975: 153).

On the one hand, many Chinese try to justify their religious preference by arguing that to be a moral person one does not need to be religious and to be religious one does not need to be Christian. On the other hand, more and more Chinese have become Christians as Christian teaching is easier to understand and has less restrictions and fetters than the others. Chinese churches are dedicated mainly to serving Chinese people and their programmes were accordingly run by Chinese priests. The affluent churches may also have kitchens, playgrounds, libraries, nurseries. However, many Chinese churchgoers have not abandoned traditional Chinese religious views. Some of them join churches for social and educational reasons (Tsai 1986: 143-147).

Chinese ethnicity is a complex issue. This could be studied within the context of international understanding of ethnicity. Many social scientists (Vermeulen & Govers 1996: 2, Jenkins 1997: 12, Cohen 1996: 59) agree that Barth's (1969: 13) reconceptualisation of ethnicity as social process soon became regarded as a classic. This shift was accomplished by differentiating the notion of ethnicity from that of culture. Barth (1969: 13-14) presented ethnicity as a form of the 'social organisation' of cultural difference. The root of this organisation is in the fact of the presence of boundaries separating groups. This model of social organisation shifts the emphasis

from seemingly 'objective' cultural traits to behaviour. He emphasised that ethnic groups and boundaries were characterised by self-ascription and ascription by others.

Any social identity must mean something to individuals before it can be said to exist in the social world. The collective cannot be real without the individuals. Cohen (1996) and Jenkins (1997: 166) started from Barth's work and directed the study of ethnicity in the broader field of the study of collective and individual consciousness. Many anthropologists now try to depict flux and process, ambiguity and complexity in their analyses of social worlds. In this context, ethnicity has suggested a dynamic situation of variable contact and mutual accommodation between groups (Eriksen 1993: 9). A basic anthropological understanding of ethnicity according to Jenkins (1997: 13-14, 40, 165) consists of four elements: ethnicity emphasises cultural differentiation although identity is always a dialectic between similarity and difference; ethnicity is cultural—based on shared meanings— but it is produced and reproduced in social action; ethnicity is to some extent variable and manipulable, not definitively fixed or unchanging; and ethnicity is both collective and individual, externalised in social interaction and internalised in personal self-identification.

Ethnicity is an identity that reflects the cultural experiences and feelings of a particular group (Spoonley 1988: 40-42). The key factors contributing to Chinese people's sense of ethnicity are that the British may homogenise 'Chinese'; and the Chinese may be sensitive to sub-divisions, whose boundaries may or may not remain stable. They have their own languages, customs, cuisine, etc. which make them fairly distinct. Living in Britain the Chinese may become self-conscious about these things for the first-time. Ethnicity becomes their refuge (Nash 1989: 90) for identity, confidence and solidarity in this new strange social world at psychological, social and cultural levels.

The Chinese 'supermarket' is an important cultural resource, which renders an important service to the Chinese community. It supplies general Chinese ingredients, spices and food, Chinese stationery goods, Chinese herbs, pills, incense, idols for worships and so on to meet the socio-cultural needs of the Chinese and provide them with the means to preserve their own culture.

The Sunday schools for children to learn Chinese in Britain have been the regular meeting places for parents, children and overseas students. They were seen by the Chinese to bridge the generation gaps and retain their cultural identity (Chan 1988: 73, Wong 1989: 77- 78). However, various external forces of mainstream education

and western cultural values are influencing and weakening the allegiance of their children to their cultural and linguistic roots.

The subjective ethnicity is reflected in eating habits (§3.2.2), the social functions of these Chinese Sunday schools, supermarkets or shops, where the Chinese socialise with each other, gossip, and put up their advertisements for job vacancies, businesses etc. The language teachers, store owner or store keepers are usually better educated. They are engaging consciously or unconsciously in the process of socialisation and reconstructing the Chinese tradition, the image of the past. Such networks of 'invented traditions' (Hobsbawm 1983: 1-14) develop new positions and patterns to organise their daily activities in order to maintain a collective identity, membership of the communities, socialisation, value systems and behavioural conventions.

The engagement of Chinese people in catering or related self-employment reflects not only their escape from racism and poor employment prospects but also their self-worth, independence and satisfaction (Metcalf et al 1997). Compared with other minority groups in the UK, most of the Chinese, particularly the kitchen staff, had the least contact with the natives because of their self-reliance (Ng 1968: 88, Watson 1975: 124-127, May 1978). Many of them could only utter a few words in English, though they had been in Britain for more than twenty years.

The bitter experience and resistance to integration by the early sojourners are shown in their self-sufficient social organisations in China Town. To meet their socio-cultural needs, the Chinese people have their own associations, clubs, churches, gambling houses, cinemas, video tape centres, accountants, information and legal inquiry services. The establishments and services provide the opportunity for ambitious and status seeking individuals to compete for leadership positions and the opportunities to express their own cultural values and sentiments. Their voluntary community separation is stereotyped by the media and further reinforced by the services provided within the community (Ng 1968: 90).

Recreational activities of the ethnic groups were one of the cultural dimensions that had not been probed in the 1994 Survey (Modood 1997c: 331). The main recreation of Chinese migrants in the first decade of the 20th century was gambling according to some researchers (Cheng 1948: 89-90, Ng 1968: 61-66, May 1978). The Casino in Britain was the only leisure place they could go to after their work at midnight or early the next morning. It is a place for them to gossip, up-date themselves, socialise with their friends, advertise their job vacancies and possibly find

a job through personal contact. Socialising and entertainment appear to be their major intention.

Based on literature (CRE 1987, 1988, Chan 1988) and my own observations, the causes of loneliness are believed to be fourfold: language difficulties, geographical isolation, cultural difficulties, and long unsocial working hours. Many ageing sojourners are looking forward to their retirement to be free from the hours of hard toil, loneliness and uneasiness. They miss the life they were familiar with and crave friendship, excitement, status and power. They are struggling with these insecure feelings and constraints to maintain their inner balance. They would prefer to go back to where they came from originally. Many Chinese stated that they would not live anywhere else if the political and economic situation in China was more desirable, and their every need for cultural adjustment abroad has only served to intensify their feeling of regret (Cheng 1948: 85). The anxiety about changes or cultural losses indicates the desire to preserve their culture, which is seen by some as a form of group solidarity (Modood 1997d: 356). Some less privileged would prefer staying where they are but change their life style, spend their meagre savings and enjoy their leisure time. Many end up aimless, lonely and try to get some part-time employment simply for companionship, board and lodging.

Chinese identities and ethnicity are changing with circumstances as new challenges and opportunities present themselves. Many of the Chinese practices are not stable and are influenced by various aspects of dominant British cultures and by new currents of thinking and feeling. Hence a new form of ethnic identity and ethnicity is emerging during the interaction with British conditions.

6.4 Racism in Britain

Racism refers to doctrines of racial superiority on grounds of colour, race, nationality or ethnic origins (Solomos 1993: 9, Atkin & Rollings 1993: 4). It includes both racial prejudice and racial discrimination (Banton 1959: 15-51). The attitude of racial prejudice about other people is common among all people, as Atkin and Rollings suggested (1993: 4). Racial discrimination is a practice which refers to those who have the power to turn their prejudice into acts of unfair treatment consciously or unconsciously, directly or indirectly (Solomos & Back 1996: 63). The concept of racism is used in practice to mean almost the same as racial discrimination (Solomos & Back 1996: 63) but the meaning of racism is not a static phenomenon from a historical point of view. It is produced and reproduced through political discourse, the media,

the educational systems, other institutions and public policies (Solomos 1993: 9) within specific political, cultural, social and economic moments.

Studies of racism in Britain have reflected on the growth of ideologies which focused on the interpretation of race, racism and anti-racism and discussion of their policies (Solomos 1989, 1993, Solomos & Back 1996: 5, Ahmad 1992, 1993, Rex 1970, 1973, 1983, 1986a & b, 1988, Banton 1959, Modood 1997d: 339). Most studies carried out between the 1950s and 1980s concentrated on the interaction between minority and majority communities in the form of 'race relations' in education, employment, housing, the conflicts arising from 'whiteness' and 'colouredness' in service delivery situations and other social contexts. Racial discrimination was challenged through the Race Relations Acts of 1965, 1968 and 1976 (Ben-Tovim & Gabriel 1982: 152) and academic debates about the issues. However, there was a relative absence of a clear theoretical perspective about the interplay between race relations and other kinds of social relations such as economic, class, gender, political, and cultural relations (Solomos & Back 1996: 5).

Miles (1982a & b, 1988, 1989) looked at this issue from a neo-Marxist perspective in the early 1980s (Solomos & Back 1996: 7, 10). He argued that racial differentiation was always created in the context of class differentiation (Miles 1989). He perceived that racism was a human construct, an ideology with regulatory power within society and interrelated with the conditions of migrant labourers (Solomos 1993: 28, Solomos & Back 1996: 7-10).

Within the context of debates about race and immigration it is noticeable that some politicians attempt to use racial symbols to construct national identity in contemporary Britain. This kind of argument is represented in Enoch Powell's 'River of Blood' speech. His argument was based on 'natural' fear of outsiders, the 'naturalness' of liking your own, belonging through lineage, complete loyalties and on 'good plain common-sense' (Ahmad 1992: 12 - 13). In Powell's terms, the number of migrants and their descendants constituted a threat to the loss of Britain's national identity and a challenge to the values of the host country. This new discourse allows the expression of racist sentiments without using the language of crude racism (Ahmad 1992: 13).

The new racism of 1980s and 1990s was coded within a cultural logic. When people using these ideas were challenged they claimed that they were not racists but merely protecting their way of life and the issue of racism was irrelevant to their arguments (Solomos & Back 1996: 18, 27 & 28). The question of cultural protection

or prevention of changes must be integrated within contemporary conceptualisations of racism. The discourse of culture and nation invokes a hidden racial narrative (Solomos & Back 1996: 19). By contrast, new concepts of 'Britishness' suggested by Modood (1997d: 359) embrace the new mix of cultures and communities that exist in the society to incorporate a respect for persons as individuals and for the collectivities to which people have a sense of belonging.

Racism is analysed here at two levels: individual racism and institutional racism. Individual racism occurs when a person from his or her prejudices treats the other unfairly simply because of his or her ethnic origin. It is often overt, individual, and intentional but sometimes can also be unintentional. Institutional racism is structural rather than psychological or cultural (Rex 1986: 108). It refers to the established and customary operational practices in any institutions that keep the minority in a marginal position either consciously or unconsciously, intentionally or unintentionally (Atkin & Rollings 1993: 4, Kroll 1990: 72, Seymour-Smith 1986: 238).

One simple example of individual racism is revealed in the derogatory term 'Chinky' used in interaction by some people to refer to Chinese people or a Chinese meal. 'Chinky' was commonly used to speak disrespectfully about the Chinese (Lee 1960: 360) and is still heard frequently among people who are not aware of its connotation and implications. Chinky is a mutation of *Qing* (*Manzhou*) Dynasty³. The term may have been invented since the Chinese were defeated by the European powers in the late 19 century. Many Chinese are unhappy to be called 'Chinky' and will engage in fighting back. Few British people understand this historic association of the term although some of them may be aware that the term is offensive.

Better understanding of different ethnic groups can improve relationships, increase respect, mutual tolerance and reduce discrimination. Without a such knowledge, health workers in the NHS tend to use stereotypes to help them provide 'effective' care (Leininger 1978, Giger & Davidhizar 1995, §1.2.4, §10.2, §10.5). They fall into the trap of assuming that ethnic groups are 'all the same' but 'not like us' (Bowler 1993). As Bowler (1993: 175) has pointed out, stereotyping potentially leads to institutional racism which 'denies the needs of the individual' (Kroll 1990: 73)

³ *Qing* Dynasty (1616-1911) is a dynasty of the *Manzhou* conquerors, who were considered aliens. Most Chinese consider that the history of *Qing* Dynasty is the history of shame to *Han* people (Dikotter 1992:25), because they perceived themselves as the descendants of *Han* not *Manzhou*. The *Qing* Dynasty was defeated in the Opium War by the West. The history of *Qing* Dynasty is conceived a national shame.

in an invisible way. It often leads to misjudgements (Torkington 1986: 50-1) and insults, and prevents offers of appropriate support and assistance. Moreover, some work on racism suggests that greater knowledge about an ethnic group can lead to more informed insults, as in the example of midwives' typification of Asian women purely on the basis of physical appearance (Bowler 1993).

Institutional racism is maintained and reinforced within institutions and has affected the under privileged. It may appear neutral but has the effect of excluding racial minorities while maintaining the privileged position of the majority. This may be found in the view of cultural assimilation as essential to citizenship and political equality (Modood 1997d: 357), in recruitment, work experience, promotion and as well as quality of care etc. Those in power use their authority intentionally or unintentionally to discriminate through the interpretation and application of their organisation's regulations (Torkington 1986: 50-1). For instance, the expectation that minorities should assimilate to the dominant culture in the public sphere, excludes their right to maintain their difference in both the public and private sphere (Modood 1997d: 358).

Another example on institutional racism is the adoption of racially selective immigration control (Rex 1986: 105) and the Nationality Act 1981, which arguably have made racism legitimate and respectable (Foster 1988: 275). Immigration control is designed to protect the interests of the host people by restricting aliens in jobs, civil and political rights and citizenship. In fact immigration policy is a sort of institutional racist ideology and practice that is propagated by the state through immigration legislation (Stasiulis 1990: 277).

6.5 The NHS and ethnic minorities

The NHS (§5.2) is reputed to be run by middle class professionals and to cater very much for middle class patterns of illness behaviour (Heller 1978: 89). Racism still operates in it. The ethnic minorities are poorly served, especially in terms of meeting language, psycho-social needs and preferences for gender and ethnicity of doctors consulted (Ahmad 1992: 7, Nazroo 1997a & 1997b: 258). The whole structure reflects the ideology of the professional community and is perceived by critics as an instrument of oppression, controlling deviance and maintaining conformity (Ahmad 1993: 12).

The guarantees of 'The Patient's Charter' (DoH 1994, 1995) stressed the state's commitment to the health of the nation and allowed the state to act as an agent

of change. It introduced a new political rhetoric and a new set of expectations in the NHS to create an illusion of a shift of power from providers to consumers on the supermarket model, while maintaining the dominant position of 'scientific' biomedicine. Increased consumerism and individualism were encouraged by these series of 'entitlements' and information but in reality the consumers could do nothing directly with them (Power 1997: 83-88). There are doubts about achieving equity in practice regarding gender, class, age and origins. The decisions regarding the who, when and how of treatment are left in professional hands (Power 1997: 83-88). Knowledge about illness and the power to diagnose has been tightly guarded by professionals whose interest is to keep tight control over their source of power.

Klein (1988: 3-20) argued along this line that the NHS cannot offer equal treatment for equal need, except equal access to doctors. As the result of 'clinical freedom', professionals distinguish 'acceptable differences' from 'unacceptable inequalities' with regard to policy making and treatments because of limited resources. In this case the emphasis on one ethnic group or another is considered to provoke discrimination against the others. To single out the needs of one group of people will divert the resources of the others. However, critics argue that if all ethnic groups have access to the same media coverage, health education and medical services, the outcomes will be different. The problem is how the implementation of these measures of equity can be achieved in real terms, given the compromises and constraints of the NHS. The solution to it remains a task for future study.

The examination of health care services reveals a dominant model of 'ethnic sensitivity' which has been emphasised and underpinned by an ideology of 'multi-culturalism' (Stubbs 1993: 38). In terms of service delivery, the argument is that there needs to be a better understanding of different customs, traditions and religious activities of ethnic minority groups (Schott & Henley 1996). The critique of this model is an anti-racist perspective, which focuses on racism rather than culture or ethnicity and attempts to transform unequal social relations into egalitarian ones.

There are many indicators of institutional racism in the health care system, despite the shortage of data assessing the nature and evaluating the experience of ethnic groups or women as a whole in the NHS. Four problems of institutional racism for the Chinese in health services emerge in the limited literature available (Kroll 1990: 77, Henley 1979: 147-160), namely, 1) a low level of knowledge of community services for the ethnic minority groups among ethnic minorities themselves; 2) the inadequate knowledge of the spiritual beliefs and customs of the ethnic groups among health workers and health authorities; 3) the social and ethnic mix of the general

population is not reflected in the composition of the health work force, which results in the mismatch between providers and consumers to address the cultural needs of the Chinese in the health care system; 4) stereotypes of the social expectations of the Chinese. These problems seem to be connected with the impact of immigration, disadvantages in language, cultural familiarity, employment, income and standards of living rather than with distinctive cultural practices (Modood 1997d: 351).

Evidence (Ahmad 1993: 1-2, Nazroo 1997a & 1997b) suggests there are two main trends: a cultural approach and an epidemiological approach in research and literature on the health and NHS health care of ethnic minority groups. The realities in the former approach are constructed in terms of cultural differences; racialised inequalities in both health and access to health care are explained as the result of cultural differences and deficits. The possible solution in this perspective demands integration on the part of minority communities, cultural understanding and sensitivity on part of the health workers. The latter approach is the notion of 'value-free' or 'scientific' approach, which uses rigorous methodology to dismiss subjective or political 'irrelevancies' such as race, class and individual differences. This approach is widely upheld by clinical medicine and other 'hard' sciences, but it is under attack (Ahmad 1993: 31).

Nazroo (1997a, 1997b: 224-258) has used both approaches mentioned above to provide a comprehensive overview of the existing research on the health of Britain's ethnic minorities (see also Smaje 1995, Ahmad 1992 & 1993). Nazroo's study was based on preliminary analysis of the 1991 Census and the 1994 Survey on Health and Ethnicity covering England and Wales. The survey attempted to measure ethnicity and health in seven areas: general health status, cardiovascular disease, some specific physical problems, weight and health related behaviour, accidents, use of health services and mental health.

The health of the Chinese⁴ was similar to those of whites, and better than other ethnic minority groups (Nazroo 1997a & 1997b) as they were more likely to be better educated, though less likely to be employed in higher or intermediate non-manual work than whites (Modood 1997a: 64, 1997b: 145). However, the psychosocial health of Chinese women was lower than white women (Nazroo 1997a: 47). As aliens the Chinese, as with other minority migrants, entered British society at or near

⁴ The interest of 1994 Survey was in the understanding of the position of ethnic groups rather than disease process. The data collected were respondent's interpretations and self reporting that may derive from their ethnic background, variation and beliefs. The number of Chinese respondents in this study was very small (214), making it difficult to generalise.

the bottom of the society, gradually working their way up as they proved themselves more respectable, better educated and better off. This constant stress contributed to a high level of psychosomatic imbalance among Chinese adults (Watson 1977: 203). This disadvantaged socio-economic status had a great impact on their general health as the result of migration, cultural dislocation, environmental deprivation, impact of racism and discrimination, even though they might have better health than some of the other ethnic groups (Nazroo 1997a: 82-109). Some Chinese exhibited varying degrees of emotional disturbance under prolonged inability to obtain jobs relevant to their qualifications, constant pressure of having low social status, fear of inadequacy in work performance, worry about family members in China, inability to effect the entry of fiancées or families and their own inability to join them. They were anxious about the future and frustrated with their general social condition.

The predominant medical model (§5.2) often attempts to exclude more traditional methods of treating or accepting disease, which are certainly still found acceptable to some Chinese (Unschuld 1985:260, §3.2 & Ch4). The sanction for alternative therapies is often obtained through the ritual of 'scientific' evaluation. The suppression of alternative therapies helps maintain the dominance of 'scientific' medical ideology (Ahmad 1993: 14). The Chinese, in my view, may interpret this as racial disadvantage and not use the services as much as the dominant group as the result of this misinterpretation. They may still consult traditional healers in preference to, or in addition to NHS health workers, even though NHS medical care is freely available.

The concept of health and illness for many Chinese people is based on the balance of the theory of *yin* and *yang* (§3.2.1). Like some British people, the health seeking behaviour of the Chinese may not necessarily involve a direct path from illness to medical services. Instead the initial health seeking behaviour in response to any type of illness is an attempt at self-adjustment. They buy themselves some cooling herbs from the Chinese shops and make themselves some herbal tea or therapeutic meals and take them from once to three times a week to prevent further deterioration. If they get better it is the merit of the wonderful herbs, if their condition gets worse, it is their bad luck. They have confidence because so many people have used them before. They are less likely than any other ethnic group to visit their GP (Nazroo 1997a: 112-113), because hardly any medical staff can understand them, their values, social expectations, norms and culture. If this fails they seek advice from family and trusted friends (Cheng 1948: 112, Chan 1987: 41, Bayne-Smith 1996: 29) and

discuss with them their problems and their solutions, although sometimes family and friends were felt too close to disclose their illness and conditions (Chan 1987: 8).

As an alternative, a folk healer is often the next step to respond to their illness. Like other Asian ethnic minorities in Britain, the Chinese are reluctant to consider outside help and have limited personal resources available to them because of the linguistic and cultural differences which interfere with their ability to obtain important health information, to communicate with health professionals, to locate health services available in their community and to use health services fully (Rack 1979: 169, Chan 1987: 41, Modood 1997a: 60-63, Nazroo 1997a). These problems are unevenly experienced. The questions of which mechanisms will facilitate prompt attendance for hospital treatment and how individuals can be helped to acquire attitudes and skills to interact between themselves and with outsiders to meet their specific needs are topics beyond this study.

When Chinese people become the consumers of high-tech, market driven hospital services, like the other ethnic minorities in Britain, they do not possess enough political, cultural, and economic manoeuvring power to force health workers and policy makers to consider, respect and respond to their health needs (Seldon 1995: 59). They have to confront competition with the host people for the restricted supplies made available by the state but also the conflicting treatments sometimes against their own perception of 'proper treatment' and the immediate problems of diet. It is also important to see how Chinese men and women perceive and maintain their family structure and relationships in British social and cultural environment. I have taken account of these questions in my interviews with the Chinese women who have given birth in Scotland. These issues are discussed in chapters 7, 8 and 9.

The food provided to postnatal women in the NHS is one example of racialised attitudes on the part of health service providers. A Chinese dish *Chop suey* was chosen by hospital dieticians in Edinburgh Royal Infirmary to appear on the menu to symbolise the choices made available to accommodate different peoples. The appearance of this dish led me to a number of interpretations. First, *Chop suey* needs no hard-to-find ingredients and little expertise to cook. Second, what was overlooked is that *Chop suey* is so commercialised that it has lost its attraction to Chinese people in Britain because it no longer consists of its traditional ingredients of different kinds of meat (including animal liver, kidney, stomach, poultry's intestine and specially prepared deep fried skin of pork) and vegetables. Third, the term *Chop suey* conveys an overt sense of contempt because of its handy, non-selected ingredients, its simple preparation and easily accessibility. And, the last but not the least, it symbolises the

nature of second class of food for the second class of citizen. The insensitivity of the catering services in the NHS to the meanings of the dish and the needs of the Chinese reflects the ideology and eating habits of the dominant population. This racist attitude in relation to food limits ethnic minority women's choices during their hospital stay and tempers their experience. Eating the correct 'hot' or 'cold' food on the right occasions and living a life free of excesses are believed important by many Asian ethnic groups. Further study may be needed to support the assumption that hospitals should cater for various dietary habits in a more sensitive way (Foster 1988: 275, Schott & Henley 1996: 263).

The communication and the relationship between professionals and Chinese women may also be negatively affected by the use of interpreters. The interpreting service for women during pregnancy and childbirth requires tact and skills to describe and explain terms, ideas and processes regarding women's health and care. Usually the responsibility for interpretation falls on anybody who is bilingual and available, for example, a family member, a friend, a professional and sometimes a child. This lack of training may lead to inaccuracy, violation of confidentiality, failure to pass on information and failure to facilitate the development of rapport between the women and her carers. The presence of a child interpreter may strain family relationships (Homma & Guillermo 1996: 116) and affect parental control of the child in future. However, the presence of a bilingual health worker does not only help to provide an interpreting service but also to promote a perception of caring about this group of women. Understanding their language is the beginning of understanding their beliefs about health and illness and their behaviour, and facilitates treating them as whole persons.

In order to survive in this new environment the Chinese develop a capacity for dual understanding of both their own views and the dominant view of how the new world sees them. Therefore the health problems and needs of the Chinese go largely unrecognised partially due to the need for the survival of Chinese individual and community and partially as a result of lack of awareness and sensitivity to the Chinese from the mainstream health system.

The present limited flexibility of the health system is largely due to a lack of knowledge and sensitivity to Chinese culture, beliefs and needs and health workers' stereotypes of ethnic minority patients (Bowler 1993). The inability of health workers to understand and communicate is problematic because this can prevent Chinese women from getting accurate information and making choices between alternative opportunities. In addition, prejudice, institutional racism and social discrimination

against Chinese women may increase and reinforce the social distance between health workers and the women.

6.6 Summary

The Chinese population in Britain is small in size, young in age, and well balanced in gender, dispersed in the country and is growing more quickly than other ethnic groups because it has more females of childbearing age. They fall into four categories from the perspectives of occupation and intention to stay: the sojourners, the businessmen and professionals, the students and intellectuals and British Chinese. They are mainly from Hong Kong, Taiwan, mainland China, Malaysia, Singapore and Vietnam. They have higher British qualifications than other ethnic groups including the British; two thirds of Chinese men and one third of Chinese women are in non-manual work. They are seriously under-represented as managers and employers in large establishments and fall far short of work appropriate to their qualifications. They are mainly engaged in or related to self-employed business.

The majority of the Chinese in Britain want to accept the host culture but in reality many find it impossible either because of lack of English language or because of cultural differences. Their experience of being migrants forced them to examine their preconceptions. They hope to retain their original culture and lifestyle to some extent and therefore seek refuge in the vitality, continuity and innovation of their indigenous culture for security and reassurance. Chinese culture thus remains the main means by which the majority of the first generation of the Chinese receive, organise, rationalise, situate, understand themselves and their particular experience in the world. They tend to adhere to their old use of Chinese medicine. They seek comfort and security in what they are familiar with, such as Chinese medicine. Yet, in order to survive they develop a capacity for dual understanding of both their own views and how people in their new world see them.

The dominant biomedical model has proved incapable of changing the behaviour of Chinese women as well as the health workers, which is the key to improved health status and the experience for all people. This mainstream health system has gradually come to accept the idea that a variety of factors contribute to health status. The health of Chinese women cannot be separated from their roles as wives, mothers, daughters, employees and so on. The mainstream health providers have become aware that whether they accept or reject their patients' cultures, the likelihood is that the women and the family may already be actively involved in other options of 'treatment' suggested by family members or other trusted persons.

The assumption based on the meaning system of the health workers may lead to the development of inadequate policy and poor health status among the Chinese ethnic groups. Individual and institutional racism are the results of this ignorance. There are many real limitations and barriers to addressing the health needs of Chinese women. Few data are available on them in general and the data that exist tend to focus on the Chinese as a homogeneous group and do not address differences, the level of integration, socio-economic status, lifestyle even though variations in their health and health behaviour appear to be closely related to their socio-economic position. This raises questions about how significant ethnicity is within this context.

Many Chinese women in the UK face barriers that prevent them from using the health services because of language and cultural differences. There is reason to believe that the health status of this group of women continues to be negatively influenced by the effects of their linguistic inadequacy and the manner of the health services delivery of the western medical model. The use of interpreters may not necessarily bring a positive outcome to them. In addition, prejudice, institutional racism and social discrimination may reinforce the social distance between health workers and the Chinese.

This chapter presented the argument that Chinese culture had provided the British Chinese with some meanings to develop a sense of how they rationalise, situate and understand the world around themselves. This chapter and the preceding ones have contrasted the social, medical and cultural contexts of Chinese and Scottish women. These contrasts provide the focus of discussion as I proceed to empirical analysis of the women's experience of pregnancy, birth and postnatal recovery in Scotland in Chapters 7, 8 and 9.

Part II

Empirical data analysis

Part II presents the empirical data collected in this thesis and as such, the main body of this thesis. The empirical data are built on the three sociological issues identified in Part I— family life and community, women's health in relation to childbearing, and institutional childbirth. This part cuts across these issues of childbearing by discussing women's perception, beliefs, attitudes, social status, birthing practices in relation to pregnancy, birth and postnatal recovery of the Chinese and Scottish women. It therefore includes women's relationship with health workers, obstetric technology and the wider social and gender context.

The empirical chapters focus on the discussion of the cultural and social meanings of childbearing and health in childbearing, the relationship between women and health workers, and ideologies of choice and control. They illustrate the differences in the conceptions, beliefs, health seeking behaviours and birthing practices including pregnancy, birthing and postnatal recovery of these two groups of women and set out to explain the differences between them.

The further analysis of empirical data of Part II supports much earlier evidence of literature that the meaning of having children, choice and control are socially and culturally defined. It provides new material of childbearing culture, especially on Chinese women who have not been studied before and whose needs may not be appreciated in the NHS. In particular it shows that Chinese women in Scotland have reconstructed their childbearing experiences while partly accepting the birthing culture of the host country. Both the Chinese and Scottish women to various degrees are in a changing theme of struggle between autonomy and control, between the mind and the body. It channels a new understanding of the relationship between 'choice', 'control' and 'autonomy'.

Chapter 7

Pregnancy: Chinese and Scottish women compared

In Chapters 3, 4, 5 and 6 the social, medical and cultural contexts between the Chinese and Scottish women are contrasted. In this chapter the pregnancy experiences of the participating Chinese, Scottish women are examined and contrasted in further depth on the meaning of having children, sex of the baby, perceptions of conception, pregnancy, morning sickness, diet modification, precautions during pregnancy, antenatal care and antenatal classes. The concepts and experiences of pregnancy of the women in the study highlight the main theme of the cultural orientation of childbearing practices and experience.

7.1 The meaning of having children

This section discusses further the meaning of having children introduced in the gender sections of §3.1, §4.1.2, §5.1 and § 5.3 about the social role of children and what becoming a mother means for a woman in these two cultures. Having a child meant to a Chinese

...an extension of my own self. It is a part of womanhood to have a child. Life is not complete without being a mother. It is impossible for a woman to understand the meaning of her life without the experience of being a mother (W12).

Two Scottish women in the study also revealed the feeling of completeness of their life of being pregnant and having a child (We & Wm).

Child-bearing and childrearing complicate the women's job situation and make it difficult for women to sustain their career. Their dual roles as a mother and an employee conflict with each other. One Scottish professional woman expressed her and the other people's concern about the relationship between her career and having children.

...they think I sacrifice my career and I think they are a bit suspicious, you know. That is not really bad. I haven't made reaction [response to what they said]...It's important to have a family. I wasn't sure what else to keep up, career or a baby. As I get older, I realise it's more important to have a family than to have a career. I feel I regretted not having a baby. So yes it seems complete to have a baby (We).

It was very important for those Chinese women who did not have jobs to have another child because

Having nothing to do here, having a child becomes a major source of my happiness in my life. It's a great joy for me to bring up and teach my child... It is very happy to see my own child is growing up. It is a sort of transfer of my own expectation. All Chinese would share this kind of feeling. Women are quite happy to devote their lives and sacrifice themselves for the progress of their children (W8).

W8 revealed a concealed alienation and isolation she experienced. All her hope and expectations in life were transferred onto her child. The loneliness and social isolation for the only child were also felt by a Scottish woman. That was why she wanted to have another child.

... the first child isn't going to have to handle being a lonely child The traffic is too bad so children are much more, I think, isolated in their own homes now, you know. They have to be supervised and brought to places. That is to have someone to play with, someone to fight with, that someone to team up to share secret with, to rebel against me and Andrew. I think that would help them, you know, that two of them can form conspiracy I think that's fine (Wc).

The idea of having more than one child to provide security and support in their old age can be observed in both groups of participating women. The same Scottish mother thought:

... In our old age,... I wouldn't like all the weight to fall on one child to care for ageing, sick parents If with two children they can assign between them whether this one would visit this weekend or another. They can hold on to make decision together. ... So for all those reasons I would be much keener to have more than one child (Wc).

Most Scottish women regarded having more than one child as an emotional need but the Chinese women, as not only the emotional need but also the continuation of family line because of the insecurity they experience in their migration and meeting different social expectations.

7.2 Sex of the baby

The social and financial influences have a great impact on the attitude towards the sex of a child during pregnancy. Though the influences have no direct physiological effect on pregnancy, sometime they have potent effects on the decision of maintaining or terminating the pregnancy.

7.2.1 The importance of having a boy

The majority of Scottish and Chinese women did not state a son preference overtly. However eight of the eleven Chinese women repeatedly stated their wishes of having a son either through the wishes of their partner, their parents, their parents-in-law or their customs .

As far as they were concerned, the sex of the child did not make much difference to them personally.

According to Chinese tradition it is better to have a boy (W6).

My parents-in-law would like to have a boy (W11).

Becoming a mother of a son had a great effect on Chinese women's self and social images (§3.1 & §4.1.2). Their social status and the confidence could be elevated immediately within the community and family once they could produce a son. This can be observed from the quotes below.

As a Chinese person, we always say to the outsiders that there is no difference of having a girl or a boy, but inside of our hearts we still want to have boys. ... The position of a woman in society or at home is very much influenced by the sex of that child. In front of her parents-in-law, having a boy, she 'finds her back more straighter than before' (W4).

W4 was a social scientist educated in Europe and specialised in South-East rural Chinese women decision making. She was aware of the problems Chinese women have to face when confronting Western cultures. Her background encouraged her to be the advocate of the traditional ideologies of Chinese women on the issues concerning women. When she confronted the changing western value of choice and control herself, she went to the other extreme trying to 'fit in' what was thought normal in Scottish context to the extent that feeling been abnormal as not experiencing postnatal depression after childbirth.

Male preference was also true for five of the Scottish women, especially for their older relatives and/ or their partner. The idea of having a son to pass on their partner's family name still prevailed among them, although their preference for a son was not stated as strongly and overtly compared with their Chinese counterparts. This might be due to the existence of a relatively fairer education system, the welfare state and social benefits.

... if this is a boy then, he can carry on my husband's last name (We).

I think, my mother-in-law [a Scot] is quite open minded. My father-in-law [a Scot] may regard boys as superior to girls. Anyway he is quite elderly now. My sister and brother-in-law have already had two sons. I think if I have a girl, he may feel happier. He hasn't had any grand-daughter yet (W5)

The reaction to having a girl or a boy was more liberal among Scottish woman participants.

I quite like, I like a little boy but really daring, you know, and I like a little girl but really girly. I think I don't worry. I think, I think, I like to have one of each, you know (We).

They seemed quite happy to state their preference for a girl frankly but not the other way round. This may be due to the influence of the public media or it may be that mothers feel they can relate to daughters more easily than to sons and expect their partners to be able to relate more easily to sons. They may also have wanted to impress me with the pride of their civilisation. Eight of them said they did not mind the sex of the child but four of them stated that they wanted to have a girl.

The woman's experience of the sex of baby is further discussed in §9.9.

7.2.2 The differences of having a girl

Only four out of the ten Chinese women expressed a preference for having a girl to a boy. Two of them presented themselves in a consistent way both in the antenatal and postnatal periods because they had already had a son before this birth. The other two expressed their girl preference one antenatally and one postnatally. In both cases they had a boy. However a daughter was thought by the Chinese women in a similar way to the Scottish women, more sympathetic to her mother's situation and caring for her mother, though she was not expected to be the main carer for her parents in their old age according to the customs, in contrast with a traditional responsibility of a son.

In Chinese traditional culture a baby girl was at higher risk of being abandoned by her parents (§3.1.5, §9.9). However, it did not appear much of a problem for the Chinese women in the study to accept the birth of their baby girl. This may be the result of constant contacts with the host culture and living apart from their extended family, especially in-laws. One urban Chinese woman reckoned there was not much difference between having a boy or a girl nowadays.

There are not many differences now. Now male children have their own homes when they have grown up. They no longer live with their parents. A girl is the same to a family. When he has grown up, a boy would not always think of the family. But a daughter is different, she always thinks of writing, or sending money home (W6).

Another woman stated

I think it doesn't matter whether you have a boy or a girl. A girl knows how to love her parents; a boy is ambitious and more interested in what goes on around him than in his own thoughts and feelings toward his parents. It's just the same whether it is a boy or a girl (W9).

The mother-in-law of a woman in the study expressed her ambivalent feeling towards this by distinguishing between urban and rural people.

We city people do not mind whether it is a boy or a girl. But I think son is much better, but we also like daughter as well. Because we are urban people, we don't mind if it is a boy or a girl. The ideal is to have a son and a daughter. A son and a daughter are the most ideal (R2).

7.2.3 Technology in sex predetermination

All Chinese women in the study expressed reservations about the traditional Chinese beliefs and practices of predetermination and selection of the sex of baby (§4.1.2).

One westernised Chinese woman in the study revealed an acceptance of the 'modern bio-physiological theory' — of conceiving a male child through the timing of intercourse, douching, coital position and desirability of female orgasm.

I read some books which said if the time of intercourse is earlier or later than your ovulation, it usually results in a girl pregnancy, because the X sperm and Y sperm. ... Because my periods has been very regular, so I knew it was about at that time. My period cycle is about 28 to 29 days. Ovulation normally takes place on day 13 to 14 (W5).

The common clinical diagnostic technology to identify the sex of baby during pregnancy are ultrasound scan, amniocentesis or chorion villus biopsy though they were designed primarily for the investigation of genetic abnormalities in a fetus when a mother is known to be at risk. All three Chinese women from Taiwan stated that these techniques were widely used for non-medical sex determination after conception in Taiwan. According to them Taiwanese couples liked to know the sex of their baby during pregnancy from the ultrasound scan they went through. It had become a common practice for a doctor to reveal the sex of fetus.

As soon as the pregnancy is known to the others, people 'definitely' [shifted to an English word to emphasise the clarity and certainty] ask you the sex of the baby. There is no doubt about it. Doctors seem to be obliged to disclose this news to you (W3).

The application of this technology was perceived to pose no threat to the life of a female new-born.

... From social cultural perspective, or relatively speaking, the knowledge of fetal sex does not influence the couple's decision for maintaining or terminating the pregnancy or at least it hasn't reached such a degree [in Taiwan] (W3).

But some other evidences showed a grey zone in some cases that they were used to terminate the life of a baby of the 'wrong' sex in some areas in mainland China (F6, Hanmer 1981: 130-2).

Two of the eleven Chinese women in the study stated that they did not want to know the sex of their baby. One of them (W9) did not want to know because it would bring worries to the whole pregnancy and the sex of the baby had long been decided anyway. Another woman (W10) thought only those people who wanted to have a boy would like to know the sex of the baby. The rest of the Chinese women wanted to know the sex of their baby before birth to satisfy their curiosity and to prepare right types of baby clothes (W3, 4, 5, 6,7, 8).

Unlike other Europeans who chose to be told the sex of baby after a scan, nine Scottish women in the study did not want to know the sex of their baby and chose to have a surprise at the birth.

7.3 Perceptions of conception and pregnancy

Not all Chinese women in Scotland related their conception to traditional Chinese folk beliefs about conception (§4.1). Seven of the ten Chinese women did not think the *yin* and *yang* theory was scientific. This may be due to the fact that nine of the ten Chinese mothers in the study had completed at least undergraduate education before they conceived. They tended to accept the modern biological model of conception and perceived that conception is the result of fusion of sperm and ovum. Some of them did not even like to mention the idea that pregnancy may occur when *yin* and *yang* meet together because the expression of *yin* and *yang* was considered mysterious and dated. Though they expressed their dislike of this interpretation of conception, they observed restrictions suggested by this theory during pregnancy.

A mysterious and fatalistic sense of how pregnancy occurs could also be discerned in the discourse of the participating Scottish women. Some of their expressions of conception pointed into that orientation, for instance, 'falling pregnant', 'catching' or 'discovering' pregnancy. But on the whole the perception of conception of Scottish women was more or less medically constructed. This was mainly reflected in their self-presentation through the vocabulary and the manner they chose, for example,

[Laughter] ... I know the sperm gets inside your tube, fertilises the egg. I know how you go through but just to explain it. [long pause] (Wh).

The words and expressions they used were those they learnt from the antenatal classes. The influence of the medical model was dominant among the participating Scottish women.

So the majority of both the Chinese women and Scottish women accepted the medical model of conception. Most of them felt that they were pregnant at least four to eight weeks before they were diagnosed as pregnant by medical professionals.

I know exactly my dates but I am just waiting to get my urine test result to confirm it (Wg).

But the fact of their pregnancy was put in doubt by the medical professionals until the availability of a positive result from their pregnancy test or ultra sound scan, even though there was no doubt in the women's mind. This indicates a gap between the perception of medical profession in the management of childbirth and women's own experience of childbirth.

Pregnancy was an integrated event with physical, mental and spiritual components. One participating Scottish woman stated that 'it is the most natural thing in the world' (Wd). Similar responses were obtained from all Chinese women, except one woman's partner.

I think it [pregnancy] is a natural process.... I don't feel pregnancy an illness, but my partner thinks so (W4).

A Scottish woman felt that people noticed her protruding abdomen instead of her face. Her abdomen became a social or 'public property' — people come forward to pat it to show their kindness and concern (Pd).

The interviews with some Chinese women suggested that pregnancy was seen as a relative state of biosocial homeostasis of *yin* and *yang*, though eight Chinese women regarded this rationale as unscientific. All Chinese women except one, were happy with being pregnant and with their body changes. The only one (W12), who was uncomfortable with the changes of body shape, felt that pregnancy had revealed to the public her sexuality and an extramarital unplanned pregnancy (§4.1). But none of them remained indoors or tried to keep their pregnancy invisible by shunning their friends. Women being visibly pregnant in public appears to be more socially acceptable to Chinese women in Scotland than in China.

Pregnancy outside wedlock is still a particularly trying experience for a Chinese woman within her community. Two of the ten of the Chinese women were in this situation. One of them tried to tell her acquaintances that she was married in order to avoid gossip and social prejudice. Another tried to avoid talking about her extramarital pregnancy and hiding it from the public eyes as long as possible. Once the pregnancy became visible, she had to face the loneliest moments of the entire experience. She could not count on the community to support her and her offspring. The unmarried Scottish couples felt more comfortable with their extramarital relationship and were more accepted in their own communities.

7.4 Precautions in pregnancy

There are many cultural precautions or restriction imposed on women during pregnancy, for example, smoking, adjustments in daily activities and mobility and 'fetal education' etc.

7.4.1 Smoking

Much social and medical emphasis was put on giving up smoking during pregnancy for the health of the baby. The efforts of anti-smoking campaigns appeared to be getting through to Scottish and Chinese women. Two Scottish smokers gave up smoking completely during pregnancy. The only smoker in the study had experienced a conflict in the rights between herself and her baby.

During the pregnancy I wasn't actually smoking as much as normal, which I am a heavy smoker, so when I said not as much as normal could be far too much for the health guide lines. I did in a sort of way. ... The baby is much an abstract thing again. I thought, well, I had right too, if the baby certainly has a right.... I am also my own person. And if I am a smoker, not a deliberately smoking in order to harm the baby but I refused to give my body over entirely to this as this was until it was born, a parasite, you know, a very welcome parasite. But never the less I wasn't actually prepared to just turn my body over to it. I wanted, I think, part of this stubbornness of continuing to smoke was related to that. I was absolutely refusing to believe that my baby was not entirely at my disposal. I think I could be wrong enough, if I am pregnant again and now I know what a beautiful thing you get. You fall in love with this baby. I think I probably will be more guilty about the smoking on the second pregnancy. Before Neil was born, I a kind of thought, well, I am your mother, you know. The downy side of having me is a sort of smoker but a lot of the upper sides, you know. If you want me to be your mother, or you choose me to be your mother. OK you choose a smoker. [Laughter] Too bad, you know. (Wc)

She curtailed her smoking during her first pregnancy but did not feel justified to give up completely. The loss of the self-image of confidence, sophistication and extroversion by giving up smoking was too much for her to lose at one go. During her

second pregnancy she gave up smoking for a year but she denied that she did it for her baby but purely for herself.

Oh yes, [Laughter]. Funny enough I stopped smoking not because of I have another baby. I stopped smoking because I wanted to stop anyway. And it is interesting once again I stopped smoking. It was terrific. I stopped actually last May so I try to stay off until the baby is born. I'd try to stop for a year. But I didn't stop because I wanted to become pregnant again. I stopped because I WANTED to stop. It comes to the firm conclusion the only way I could and would stop it, it's not for any baby. I didn't stop the first one, though I would love him to death so I would have done anything really to protect him, to protect his health (Wc).

This woman's statement implied that anti-smoking messages which focus on the health of the fetus are not always the way to change behaviour. She expressed a strong maternal need for a balance between her own psychological and physical well being and that of the baby. When it came to the integrity of an individual, the right of the mother came first before anything else in this case.

None of the Chinese mothers in the study smoked. Their responses to this question all confirmed that smoking was not good during pregnancy for the women and the fetus. According to them and their cultural expectation, the interests of the fetus should have to come before their own.

7.4.2 Adjustments in daily activities and mobility

Many adjustments in daily activities and mobility have to be made during pregnancy according to Chinese culture (§4.1.4). Three Chinese women from Taiwan stated that they would restrain themselves from hammering a nail into a wall, sewing clothes, cutting with scissors or moving the bed in their house.

My mother said if you use scissors to cut things the baby tends to have cleft lips. ... In Taiwan I know my mother would tell me not only not to move house but also not to move the bed. If you have to move the bed, you have to be very careful. You have to use broom to sweep the floor first to indicate to Taishen God that you are going to move the bed so that not to disturb him. If you can do without moving it, it would be better not to move your bed. My younger sister had this belief. She had quite a few pictures but she refused to nail the wall and hang them. She had to wait until she had her baby before she hang those pictures (W3).

Though two Taiwan women were a little more sceptical about these beliefs, they did respect them and adhered to them during their pregnancy in order to free themselves from worries and make their parents and parents-in-law happy. Others tried not to think about them but felt somewhat ambivalent towards these beliefs and practices.

No house moving during pregnancy, No nailing because this may puncture *taiqi* (uterus). I pay no attention to all these, but I feel they still have their meaning in it. I ...try not to think about those things. I feel if you care about those things, you put too much load on your mind. This does not mean I don't believe those sayings (W5).

The women from mainland China knew little about these precautions from their folk, domestic and formal education.

All the Scottish women suggested that moving house during pregnancy was not a big issue for them but it certainly was a stressful event.

That was stressful. That was not very ... It was really bad until the point we found a place to move into. After we had the place then it wasn't so bad because I knew we were planning to go somewhere.... you know, after the baby is born that wasn't too bad (We).

They in general stated they still continued to go to the places they usually did, for example, bars, pubs but they did not drink at all or sometimes they did drink but much less than before.

The Chinese women indicated that they did not associate darkness with evil spirits (§4.1.4). They continued going out in the evening as they usually did but they always bore in mind the custom that pregnant women should rest more, take things easy, not eat too much, not wear too many or tight clothes otherwise the baby would be born weak. Some of the Chinese mothers reduced their outdoor activities in case pedestrians bumped into them or they caught airborne infections and became exhausted. The educated or westernised Chinese women had a different feeling towards the restriction of mobility during pregnancy.

In fact I feel much better after doing something. If you rest all the time, you feel bored. I think apart from the physical body of the mother it is important for the growth of the baby. The psychological state of the mother is also very important, too. After doing some housework, I felt very good though I was a bit tired (W4).

Both, Chinese and Scottish women avoided lifting heavy items, climbing ladders or mountains because the balance of a pregnant woman is not very good and injury is possible.

All Chinese women were subjected to social restrictions imposed on them, for example, their diet, sexual activity, their conduct and prescriptions of what they should and should not do. Nine Chinese women did not associate pregnancy restrictions with superstition but perceived them as means of protecting the health of

themselves and their fetus. Many restrictions on mobility placed on a pregnant woman were not designed for the protection of the mother but for the fetus.

7.4.3 *Taijiao* (fetal education)

With regard to the popular belief of *Taijiao* (§4.1.3) was felt by the women in the study that it would do no harm but good to their baby. Though many of them did not believe it but felt that they could not resist it. They hoped if they were lucky they might be able to have a talented or beautiful child by looking at nice pictures, being surrounded by good looking people, listening to beautiful music or talking to their child. A well educated friend of mine was convinced that her child's extraordinary ability in speech was acquired through her talks with her fetus during pregnancy (F2). One Chinese woman preferred to talk to her fetus silently.

I felt strange if I talked to my baby loudly. I often used my heart to talk to him. I often have a dialogue with him in my mind, though I think I should have verbalise what I wanted to say, but I've never really spoken them out. It may be better to verbalise what I want to say, but I never manage to do so. I really enjoying talking to my baby silently (W5).

The Scottish women did not have the notion of fetal education but they were aware of the importance of the maternal state of being happy during pregnancy by promoting breathing exercises, listening to music or a radio, going to theatre, taking a long walk, or swimming, or soaking in a bath.

7.5 Diet for women during pregnancy

Pregnancy is a one of those special times when a well balanced diet is advised both in Scotland (§5.3.1.4) and in Chinese communities (§4.1.5) because it is believed that the diet will affect the health of the baby throughout infancy and into adult life. This common knowledge is shared by both peoples.

The choices made among the Scottish women were mainly based on a perception of the importance of three basic food groups - carbohydrate, protein, fat - plus vitamins, mineral and fluids. In addition they also took their own preference and their financial situation into consideration.

Calories and protein. I always eat chicken anyway. I look for bargains (Wg).

... lots of fibre, lots of protein, non-fat, you know, low fat, protein, chicken, or vegetable, tofu, or things like that; and fresh fruits and vegetables if possible, nuts eh + and some kind of calcium and make sure lot of iron, you know lot of broccoli ... calcium and protein are good for muscle building and drinks for vital and fresh vegetable for vital and oyster for iron, beef for iron.(We)

Calories were usually the measure used among the Scottish women to express the energy they required from their food. Food avoided for them during this period are liver and soft cheese.

The prescription and proscription of modern diet were accepted by the Chinese living in Scotland but they also observed their traditional advice because they believed that it had stood the test of over 3000 years. Instead of calories Chinese women in general used 'hot' and 'cold' (§3.2.2) to measure the balance of their diet. 'Our food can be divided into cold and hot (W3)'. Generally speaking cosmological harmony was re-emphasised during pregnancy among the Chinese women. The pregnant women should be 'hot' in order to maintain pregnancy therefore they had to avoid 'cool' or 'cold' foods where possible. Alcohol consumption was permitted but only in moderation. Special herbal teas were taken as tonics from early pregnancy to the eighth month to strengthen the womb.

Eating for two, or too much *bu* (§3.2.2) food intake during the antenatal period, was considered by Chinese women to increase too much maternal heat and foetal weight. The surplus heat accumulated in the body could also cause cosmological imbalance of *yin* and *yang*. This cosmological imbalance would result in miscarriage or difficult labour due to a large baby.

Diet therapy was used by all Chinese women in the study as a prophylactic measurement to prevent any cosmic imbalance of their body. The value of diet therapy was changing with the rapid changes in the development of sciences, for example, the animal or poultry liver was once considered good for blood building in pregnancy but now harmful and to be avoided in Taiwan and Hong Kong (W2, 3 & 5). They chose hot food but cool flavour of food (§4.1.5), avoided trying new food or food they did not have before and avoided everything that was greasy, spicy, sour and deep fried. The food they had was always well cooked in accordance with customs. Their addictions in tastes for instance, spicy, salty food etc. had been curtailed during this period. Any food or medicine that could stimulate perspiration, micturition and defecation were avoided. They did not take western medicine, if it was possible, not even aspirin or paracetamol during pregnancy, because they worried it might harm their fetus and cause fetal deformity or miscarriage (§3.2).

Mango and pineapple (§4.1.5) were thought too hot for pregnant women by the Chinese women because, especially, pineapple contains a chemical which can

cause skin rashes, and sting the tongue, if the soft skin thorn of the pineapple has not been discarded completely and soaked in salty water properly¹. That was why pineapple was thought to cause miscarriage (Martin 1990). Watermelon, melon, banana, gourd, tomato, Chinese cabbage and mung bean were 'cold' food (W2, 3, 5, & 7). Watermelon and cold based food were considered having diuretic, and cooling effect so they were thought too cold for pregnant women in the first three months because they might sometimes cause diarrhoea and/ or miscarriage as well (W7, W3).

Though prawns were traditionally advised to be avoided (§3.2.2 & §4.1.5), they continued to appear in the diet of two Chinese women during pregnancy. Lamb and mutton were not the first choice for a Chinese in general, especially the southerners because of their special odour in cooking. There was only one woman (W4) in the study who mentioned that she tried lamb once in a restaurant and found she liked it during her pregnancy.

7.6 Morning sickness

Morning sickness² is one of the many physical changes and minor complaints during early pregnancy, alongside painful and swollen breasts, nausea, fatigue, lassitude and irritable bladder. It is mentioned here simply because it was one of the most frequent minor complaints occurred in the discourse of the participating women. In Chinese medicine it is called *ezu* or pregnancy induced vomiting, which appears to be more accurate. Though the term, morning sickness is often referred to in textbooks, the women in the study stated that it was not an accurate descriptive term. They reported that the sickness was not confined to 'morning' but could occur at any time in the day.

There is no morning sickness, but all day... I felt really sick all the time. I didn't just have morning sickness (Wb).

It is also important to note different aetiology of morning sickness during pregnancy gave by some Chinese women in the study. They thought it was due to too much heat in their liver (§ 4.1.5). The different interpretation of morning sickness has

¹ Sometimes having pineapple may cost life, if it has been taken too much at one time. Every summer during the harvest season of pineapple there always were a few cases of pineapple poisoning in the casualty departments in the southern parts of China, and a couple of deaths were reported in the areas where pineapple was grown in large quantity.

² The causes of nausea and vomiting in pregnancy are unknown, though some textbooks (Bennett et al 1989:114) indicate some hormone changes. Human chorionic gonadotrophin is found in large amounts until the placenta takes over from the corpus luteum at around 12 weeks. Oestrogen and progesterone are also contributors during pregnancy.

reflected a different world view, a certain way of belief and practice. The presence of nausea was regarded by a Chinese woman in the study as a favourable prognostic sign of a single fetus pregnancy because the risk of abortion prior to the 20 week was thought to be less when nausea was present. But the greater gestation age and bigger baby were thought associated with women with no symptoms of nausea and vomiting because the woman could have a free choice of food and no restriction on her daily activities. However neither Chinese nor Scottish women thought that morning sickness would affect the growth of the fetus.

The absence of nausea and vomiting was thought by Chinese women as *Xu* (weak). The condition requires not only to strengthen the woman's *qi* (§3.2.1), but also to increase her nutritious food intake (§3.2.2, §3.3 & §4.1.1) or take medication sometimes to help her blood building to maintain the balance of *yin* and *yang*. Once *qi* is strengthened, the other symptoms would be corrected.

When morning sickness was present, all Chinese women stated that they would choose light food — vegetables, soup, porridge, rice and extra lean meat — while Scottish women stated that they would usually have biscuits, vegetable soup, sandwich, small frequent meals, as they were advised by the dietician and antenatal leaflets. The Scottish diet usually consisted of the food that they liked 'I kept on eating, just a sort of nibbling (Wb)', and the Chinese diet consisted of the food they liked according to their understanding of traditional equilibrium theory of *yin* and *yang* status. The rules of equilibrium of *yin* and *yang* were carefully observed by most Chinese women in the study during the period when they had morning sickness. If they were hot, cold food was taken and if they were cold, the hot food was more appropriate. Spicy, greasy or smelly food were taboos for them. While treating the symptoms of vomiting, they always bore in mind the requirements of the fetus.

7.7 Pregnancy menace

One woman indicated that women were advised not to kill animals during their pregnancy in case the animal killed may be incarnated, therefore to kill an animal meant to kill your own child. It was fine to consume meat for the women once she did not see and did not do the killing herself.

The shadow of pregnancy menace (§4.1.6) still remained at the back of the Chinese women's mind. Six of them expressed their reluctance to attend a wedding or a funeral in case they may hurt the other's feeling, though they themselves had reservations about this belief. Half of the pregnant women in the study would like to

observe the custom of restrictions during pregnancy and the other half would not as they had not heard of this before. Those who expressed that they were still quite happy to go to a funeral or wedding, if they had to, were from mainland China because these customs have been considered as feudal superstitious beliefs and banned since 1949.

There is not sufficient evidence in this study to support the concept that parturient women are pollutants apart from some residual avoidance of weddings or funerals among some Chinese women. Though they were unhappy or reluctant to attend weddings or funerals, they no longer associated themselves with pollution or pollutants. Nevertheless, women in both cultures reported that they have more body cleansing and room cleaning during pregnancy, which they explained in terms of maternal instinct, nest instinct, an increase of body metabolism or the daily necessity of body cleansing.

7.8 Antenatal care

Antenatal care of the pregnant women consists of two major parts: antenatal check-ups and screening, and antenatal classes (§5.2).

7.8.1 Antenatal check-ups and screening

All women in the study considered that they had benefited from the antenatal check-ups and the screening tests — for instance, urine, blood, Alpha-fetoprotein (AFP), cardiotocography and ultrasound scan — except one Chinese woman who was not happy about the frequent blood tests. Some Chinese women stated clearly their preference for medical staff to midwives and their deference to medical authority (§3.3, §4.2.4). Both groups of women in the study

... tend to err on the side that obstetric staff were knowing what they were doing. What they were doing was necessary. They are quite happy to accept it (Pd).

The quote above indicates a faith in doctors. The women attended antenatal check-ups as required even though some of them considered them too often and too brief. One rural Chinese woman (W9) who did not book in until she was five months pregnant because she worried that she had to pay these antenatal services. She and another woman from the rural China were surprised that all these services were free to them.

Blood pressure monitoring and urinalysis were thought useful to detect signs of pregnancy induced hypertension (PIH) or pre-eclampsia (§5.2.1). A Chinese obstetrician consultant (P1) felt the rate of all those induction of labour and elective

caesarean sections because of PIH in Scotland was unacceptable. In her view the symptom of PIH is transient and self-correcting in many cases. She did not think there was enough clear clinical evidence to support and justify this active management because none of the asymptomatic cases in her hospital in Shanghai was induced or sectioned before term and the health workers there put more emphasis on the better survival of a termed new-born than a premature baby.

In general all women found that attending antenatal clinics was an enjoyable and profitable experience. The sixteen first time mothers in the study felt that the frequency of antenatal visits was just about right although some midwifery researchers (Hall et al 1980, Hall & Chng 1982) suggested reducing antenatal visits to half (5-6 visits) for those normal pregnant women so that the system could make the best use of the resources and devote more time to those who have problems. The women in the study felt obliged to attend antenatal clinics for the sake of their babies. They made those visits not really for any medical reason but for reassurance. This reinforces their reliance on their doctors and medical surveillance.

Five Chinese and four Scottish women were offered amniocentesis (§5.2) to test for genetic disorders. Only one second time Chinese mother declined this option because:

I thought though I was getting old, I was still in pretty good health. It was no need for me to do this kind of test. ... I feel this kind of test was never done in China. I don't want to think so much about it. [Laughter]. I feel my daughter is perfect (W8).

She decided to refuse this genetic test as a form of prediction and let nature take its course. In the end she had a healthy baby girl and retained her sense of being in control. No Scottish women in the study refused amniocentesis.

Four of the ten Chinese women expressed their dissatisfaction with their GP services because their waiting time was too long and there was a lack of personal interaction.

My GP's attitude towards me was awful. At first, I thought perhaps he came across this kind of things too often and got used to the routine. ... Every time I had to wait for more than half of an hour or longer before I can see him and the examination just lasted a minute or two and that was it (W6).

There were no complaints from the Scottish women except Wb, who thought her GP was too young to have enough experience in the care of pregnancy and birth.

Hospital service was also felt much to be desired. One Chinese woman was referred to a hospital for some further blood glucose tests by her GP but she was advised by the hospital doctor to return a week later.

Though they [doctors] spoke kindly, what they said was cold and lacked human feeling. It seemed to me what they wanted is to get me out of their way. They could not understand the worries I had for that week. They should have given me the test that day or as soon as possible (W5).

However, W4 had a different experience in hospital.

The first time when I was in hospital, the hospital gave me a deep impression. ... I was deeply moved by what the doctor said 'You are the princess. What we are doing is for you and with your permission.' When she was examining me she had a phone call, she apologised again and again. I don't know if they treat white people differently. Anyway I feel it is good enough for me (W4).

Antenatal screenings and check-ups tended to raise the expectation of Chinese women and disappointed them by unfriendly long waiting hours.

7.8.2 Antenatal classes

The attitude towards antenatal classes was different, because they had no immediate effects on the fetus. Two Scottish women did not attend any antenatal classes because they thought the knowledge and coping skills of pregnancy, birth and postnatal care could be achieved from reading, watching TV, talking to or phoning parents(-in-laws) or relatives, or sometimes from human instinct. One Chinese woman did not attend any antenatal classes because of her poor English. The rest of the women attended their antenatal classes four to eight times during their pregnancy.

Three Chinese women (W1, 7 & 9) were reluctant to go to antenatal classes simply because they experienced some degree of frustration and futility in trying to express themselves in the situation of need. If they had any queries they would phoned their close relatives or friends for advice. All the Chinese women in the sample group happened to be first generation migrants. The Chinese language was not a problem but the lack of availability of maternity information in Chinese was.

It's no point having the information available, ... if she is unable to read it. It's better to have Chinese version ... underneath.' (Pd)

There was much emphasis recently on health education and the value of making 'informed choices' but there was not any information on maternity care in their language. Their needs and right to those 'informed choices' became empty words.

There was an individual session service available in antenatal education for those women with limited English according to a midwife educator (Pd). These individuals were identified at booking clinics and sometimes they were referred by their health visitors. The midwife in parenthood education would contact the women at about twenty weeks.

We have many women whose understanding of English is negligible, when they come here. And many of them work in the restaurant business. Again getting time off to attend sessions from that point of view it is very difficult for them. What I do with these women later on, as I write to them and offer opportunity to meet them on an one to one basis either with a member of their family translating for them or I use anyone in the interpreting services. They provide a translator. So it is very important at the booking clinic that their booking history is taken and the girls write down what language they actually speak, like Cantonese or Mandarin. we have some very limited information available in Cantonese. I normally find their attendance is very good (Pd).

Though six Chinese participants had difficulties in their understanding and communication, none of them had been offered this service. One did not attend any antenatal classes simply because she had no English at all. All Chinese women stated that they were not aware of this service available.

Another difficulty for some of the Chinese women in attending the antenatal classes was their unusual work schedules, especially in the case W3 and W7. They felt reluctant to take time off work as many of them were involved in their family or friends' business.

Some women suggested that antenatal classes were 'boring' (W8), not suitable for the needs at different stages of pregnancy and the pregnant women should be encouraged more to share their mutual experiences.

I felt the classes during the early pregnancy were too little. When we were 20 week pregnant, it seemed to me I was not as eager to learn as before. Before that I found I had great interests in learning what was going on. I wanted to talk about how I felt and to hear what the others felt when they went through the same stage. It was no need for midwives to talk too much about the 'knowledge'. The more important thing was to let the women to talk about their experience, so that they can understand themselves better. It seems to me what the midwives wanted to convey was the 'knowledge'. I felt this was not so important. Every time I felt pity at their attitude and their approach. They had spoken too much. I think they should have let those future mother share their mutual experience (W5).

The midwife's role in antenatal classes was suggested not only as a means to impart their knowledge, to prepare the women for the event of childbirth and care of their new-born afterward, but to validate women's own knowledge.

One Chinese woman thought that antenatal classes left a lot to be desired.

My husband felt that midwives tend to think men know nothing. He felt a bit upset each time when he went to the classes. He felt that the midwives knew little about his generation. He has been quite good and been able to become involved (W5).

The feed back from the Scottish women was more positive in general except for one middle class primigravida (Wg). She preferred reading all the information available to her rather than attending any antenatal classes. Another Scottish woman (Wh) stated that she attended some of the classes but her main information input was from her own reading.

Many women felt the information from the classes was not enough. This was especially true on partners' education, care of the new-born, etc. With regard to this one woman thought: 'I don't think they go very much into baby' (Wj). Another woman stated

I don't think they [antenatal classes] are enough. There is only one for the partner. I expected more physiotherapy. The physiotherapist shows you position in labour and how to breathe and how to relax and how to do antenatal exercises. And I felt that partners should be invited to that. It would be much more useful if they could have been there. All they were invited to was a hospital visit in the evening and to be shown around the labour ward, postnatal ward, shown them the equipment and what to expect when they got at home. That is a bit. I don't think it is enough (Wb).

The quote above reveals two problems. First, Wb favoured the antenatal classes but she also felt the contribution of psychological and social components of antenatal classes had not been well balanced. More classes for her partner would secure and strengthen his support which she needed. Second, the quote indicates that antenatal classes followed the medical model, focusing on the individual in trying to eliminate certain kinds of behaviour and encouraging her compliance with medical advice. It did not encourage her self-reliance and link her behaviour with the conditions of her daily life.

One Scottish woman attended National Childbirth Trust (NCT) classes in addition to the hospital antenatal classes. She thought NCT gave her a different approach to the NHS system;

I think what I found the NHS — and that I like -- the midwife said at the end of the day is what's going to happen [Laughter]. What I mean is that if you are going to have this baby, you have to go through labour and then you are. And the NCT is a little bit like you got to think about really different things, who you want, where you want to be, whom you want, what assistance you want to accept, what kind of relief you want to have. They are critical about the NHS. They can be without even looking at the whole situation (Wj).

But she also emphasised the apparent problems of the alternatives.

Two Chinese women suggested that hospital antenatal classes were more scientific than the advice and experience from their mother and/ or mother-in-law because they

pay more attention to traditional things, such as what we already mentioned, no nailing, no moving house or furniture. My own mother also told me the same story, I think I try to forget them. Mother and mother-in-law are more conservative and they only touch the subject, when they discuss with you. Many things they don't want to go any further as the hospital staff did (W5).

Domestic advice within the Chinese family had its limitations. Only two couples had extended family around locally because of the immigration control. The Chinese were as mobile as any other groups in seeking employment therefore it was often practically impossible for them to adhere to the tradition of care provided within a family.

7.9 Summary

The findings of this study support earlier evidence from the literature (Oakley 1984, 1992a, Kitzinger 1977, 1984, 1987, 1992, 1996, MIDIRS 1996, Neilson 1995a, DoH 1993a). Perceptions of conception, pregnancy and its care are shaped by the social and cultural environment. Pregnancy has been unanimously recognised in both groups of women as a human reproductive process rather than an illness.

The conflict between a woman's roles as a mother, an employee or a professional surrounds her decision of being pregnant. The sex of the baby attracts greater attention by the Chinese women. The preference for a male child is historically more predominant in the Chinese group than that of the Scottish possibly because of the social welfare and domestic environmental factors. There is some evidence that some of the Chinese women were surprised that they could use antenatal facilities free.

Pregnancy was perceived as a social event among the Scottish women in the sense that they were supported by the services provided in their communities, such as medical antenatal check-ups and parentcraft classes. Chinese women in Scotland presented their pregnancy mainly as a private event that they had to rely heavily on their extended family network for advice and assistance despite the existing antenatal services. This may constitute one of the reasons for low attendance at antenatal classes, apart from English problem. Chinese women had also to incorporate the perception of the medical model into their tradition customs and beliefs, when they attended for antenatal care.

Scottish and Chinese women were subject to many their own social constraints, such as medical culture, the prescription and proscription of their conduct

and diet. The state of remaining happy was an example for them to achieve either through fetal education, exercises or other activities. Chinese parturient women were seen as pollutants in literature but this perception was disappearing among the Chinese women living and settled in Scotland. It may be a great help for the health workers to be aware of Chinese adjustment of daily activities and food in order to provide appropriate and acceptable nutrition advice for Chinese women.

Following this discussion, Chapters 8 and 9 document the analyses of women's experience of childbirth and postnatal care respectively and the analysis finally ends with a chapter of conclusion exploring changes that would be necessary for any meaningful solution to the problems of these two groups of women in the existing health care system.

Chapter 8

Childbirth: Chinese and Scottish women compared

Childbirth is the pivot of childbearing and it is the most institutionalised stage in the process of childbearing. The social and cultural elements in childbirth are surrounded with issues of 'control' and 'choice', which are correlated with but not necessarily opposing to each other (§4.2.4, §5.2, §5.3). This raises questions about the relationship between the women, the baby, the health workers, obstetric technology, wider social context and their impact on the women's experiences of childbirth,

This chapter examines the empirical data on the issues of

- 1) women's choices for the birth;
- 2) the clinical application of obstetric technology including monitoring, intervention and labour pain management;
- 3) the meaning of different birthing practices for the women involved e.g. 'normal' and 'natural' childbirth; and
- 4) the relationship between doctor, midwives and patients.

8.1 Women's choices for the birth

Some studies have found that the expectations of having choices and being in control were associated with positive psychological outcomes (§5.3). 'Choice' and 'control' (§1.4.2, §10.4) are professional strategies to tackle the problems arising in modern obstetric technology and hospitalisation of childbirth, which have altered the experiences of women. Women's choices and control over their birth are mainly displayed in (1) birth plan (2) place of birth, (3) the presence of the partner, (4) position of birth and (5) food, during childbirth. They attempt to exercise control and to rediscover the meaning of their birthing experience through these choices.

Informed choice (§5.3.2) was thought a recent invention in the western medical culture introduced to Scotland a decade ago (P2). It is interesting to see the different manner in which the women in this study approached their choices and maintained their 'control'.

8.1.1 Birth plan

A birth plan (§5.3.2) now is designed as a positive measure for the women to exercise their control and make their choices known. There were three ways of making a birth plan among the women interviewed: by a standard birth plan during the antenatal period, by negotiating with midwifery staff during labour or by both. The variation depended very much on the practice of different maternity units, the motivation and desire of the expectants.

Sixteen mothers interviewed were offered a standard birth plan at their booking clinic and a brief verbal discussion of it prior to their labour in the labour suite. Two Scottish and one Chinese primigravidae did not complete their birth plan and had only a brief verbal discussion prior to their labour because of the unpredictable nature of childbirth. There is no clear instruction as to whether the woman should tick one or as many choices as she wishes within each multiple choice in many instances. This menu style plan also limits the choices that are available and helps the midwifery staff to predict and control the choices made by the women. The four women with no standard birth plan happened to be Scottish. Three of them had no idea how to write out their individual birth plan and one of them did not want to do so even though she had some knowledge about it because what she wanted was the presence of her partner and there was no problem in achieving that.

Most of the mothers felt that a birth plan could at least give them an idea of what to expect during the labour.

I think I talked to my friends who said that their birth plan, at least, giving them an idea what they wanted to do and what they didn't want to do. None of them followed it (Wj).

The process of constructing and updating a birth plan in this context is a process of a positive learning experience as the pregnancy or labour is progressing. A birth plan of this kind is not only women's prescription or proscription but also their unpredictable plans, should emergencies arise during the birth, they can change their mind accordingly. This can be observed in the cases of Wa and W12. Both of them planned to be in the pool during their first stage of labour and neither of them had a chance to use it. Eventually they both had to accept an emergency caesarean section because of fetal distress. The birth plan could at least remind them of what they wanted before birth and what actually happened after it.

A birth plan was intended, on the one hand, to record women's choices and help the midwives know the preference of the women and comply with them as much as they can. On the other hand, a detailed birth plan could intimidate some women as they were afraid that they had to stick to their choices and it might also challenge and upset midwives by its 'unrealistic demand' according to a labour ward sister (Ph). The birth plan was regarded by some mothers, as raising an unrealistic expectation that childbirth was plannable and controllable by them. The actual experience could make women feel that their birth was something beyond their control.

... what you would like to happen often in many ways is miles away from what does happen. And that's the way, you know, that's all you can do is just to go to the situation you are in. ... I can't actually see the value of that account [the plan] because it is so contingent on the circumstance. You write as you go. You speak as it goes, you know. You may have the labour ward sister here and say 'would you mind' the baby's heart beat going up to the stress level as it was before, so you know, you are a kind of 'Oh baby',. Things happen all the time and then they say 'This baby isn't moving, we have to give you an episiotomy.' And you put it in your plan 'Please don't cut me open'. 'Of course', then you say 'of course cut me open just let this baby get out' (Wc).

Having a birth plan is to many women an attempt to gain greater control in a situation in which they feel they have little in terms of eventual outcome. This sense of control does not necessarily mean the real ability to determine the outcome of an event.

My birth plan was in the first stage in the birthing pool in the hospital, certainly not to have an epidural. I had no intention of that (Wa).

This mother wanted to control her own labour and her own body through careful planning but she was disappointed by the caesarean section she eventually had, which spoiled her beautiful plan.

I was in shock to be sectioned, because there is a very good family history of having normal deliveries. ... I felt regretful. But at the time when they actually took me for section, I just wanted the baby to be safe ... I'm disappointed to some extent. I would like to have a vaginal delivery, but again, I think I realised to have a healthy baby is what is important and if I have another baby, I have another section, just be the fact of life for me. I'm not desperately disappointed ... I think I can put it into perspective with the happy, healthy baby here (Wa).

The expressions of 'I was in shock ...; I felt regretful ...; I am disappointed to some extent ...; I'm not desperately disappointed...' give a good picture of the step by step process by which this woman reacted, felt, coped with her disappointment, her ambivalence, and came to see her childbirth in positive terms. This kind of process was shared by four of the Scottish women who had made a birth plan.

One Scottish woman thought making a birth plan required a certain amount of information and an ability to make sense of the information and to take decisions on that basis. Though information about choices for a birth plan was thought to empower people, it could not give any true sense of control because of the unpredictability of the progress of labour.

Prior information does help. It gives you more sense of control of things. It doesn't actually give you ultimate control.... It comes down to the behaviour of your baby, which, you know, all the amount of prior information can't tell you how your body is going to behave and how the baby is going to behave upon being born. All I know is the baby will decide whether I will be induced in April and two weeks later. And that's no matter what information I have, there's not a great deal I can do to control, say, that particular thing happening (Wc).

This expectant mother talked of the baby as having a will of its own, 'baby will decide', 'baby chooses not to go on or sit down on the job or not to push way through'. She thought the birth plan was so contingent upon the baby that it did not empower her but challenged her and led her to her disappointment.

My birth plan has two things in it only. One, I don't want an episiotomy and two, I like drugs. I've got neither. I got an episiotomy and didn't have drug. (laughter) So the birth plan absolutely did nothing (Wc).

Her reaction towards the birth plan in relation to the onset, progress and outcome of labour is echoed in the testimony of all participating women. Most of them experienced to various degrees their inability to determine the outcome of their labour.

A birth plan was a new idea for many participating Chinese women. Four of them were not aware of its existence though they got it from their booking visit because they were unable to read it. When I asked them questions about the birth plan, they did not have any idea what I was talking about and started to look for it. Three of them asked me to interpret it and fill it in for them. One of them had no idea with whom she could discuss the birth plan(W8). It appears important to have a Chinese version of the birth plan as a midwife educator suggested:

It's no point having the information available, if ... she is unable to read it. It's better to have a Chinese version, or English version underneath (Pd).

One Chinese primigravida went into labour at 36 weeks gestation with no time to make a birth plan. She felt retrospectively that

Now I think if we had made a plan, perhaps we might have a better idea what was going on, because when you made the plan you had to go over all that material. That's why when they mentioned vitamin K injection, both of us had no idea what it was about and for (W4).

The main benefit of making a plan suggested by this woman was to obtain some idea of what was going on. Her experience further demonstrates the potential value of a birth plan when a communication problem is present.

But two Scottish primigravidae with no birth plan did not feel that they had missed anything. They felt they were knowledgeable enough about childbirth and about what they wanted to know through their reading and television programmes.

I read what I want to know... I find out what I want to know, like breathing.
I've seen things on TV in that. Mind you every one is different anyway (Wh).

They did not feel the need of making a birth plan because of the uncertainty of childbirth and were quite happy to discover that they did not miss anything in the end. They acknowledged the brief guidance of their midwife at each stage of labour to choose what they would like to happen during their childbirth.

Two of the ten Chinese mothers reported that no one asked them about their birth plan though they had spent time to fill it in. One stated

I feel it [birth plan] was not much use. ... She [midwife] did not ask me for my birth plan. Anyway I handed it in, She did not bother to read it at all (W9).

The other Chinese woman felt the same.

So my whole birth was carried out according to their plan rather than mine. So my birthing plan became useless (W8).

By contrast, no Scottish mothers reported that their birth plan had never been read and discussed with them. This in fact was a complaint of a poor service for Chinese women. The contributing factors to this different experience may be the existence of language and cultural barriers. But what is unusual is that the midwifery staff seemed not to have read the woman's birth plan when there was an obvious language and cultural barrier.

A labour ward sister (Ph) felt that there were many choices available for the women in their birth plan and that most women knew what they wanted. But the study did not agree with this. The majority of Chinese and Scottish women stated that they got lost with those choices and did not know what to choose. It could be difficult to make an informed choice without much knowledge of the medical system. This was especially marked among the Chinese mothers.

There are so many choices and I have never tried any one of them before. I haven't got any personal experience about them. I have no idea what to choose, for example, there many choices of analgesia, such as TENS, gas, injections. I really have no idea how to choose them. I don't know which one

is better. I decided to choose ... the one most people use it (laughter). And the one that does not have side-effect (W8).

It is difficult to make a decision of whether to have it [vitamin K] or not and the baby's chance of having leukaemia or not. ... If the majority people have it and we'll decide to let our baby have it. ... We choose to let our baby have it simply because that midwife mentioned that 90% of people have it (W4).

It is important to note that it was quite common among the Chinese women in the study to choose something that most people choose as it is assumed that the majority would do they consider safe. However safety was not the main reason for following the majority. What it does is to highlight their faith in 'normal' institutionalised birth practices being safe. It may also show their strategy for surviving as immigrants in a foreign country — to try to fit in and not to stand out of the crowd any more than they have to in this new and alien culture.

A birth plan is a two way communication between women and midwifery staff though it may give false expectations and lead the women to disappointment. There are no hard and fast rules in a completed birth plan. It is a working document which requires constant updating and negotiating according to the women's condition during the pregnancy and birth. Some women felt information and access could not give any sense of power and final control simply because of the uncertainty of childbirth. After all many women did not really feel the birth was planned by themselves. It can only provide some basic information for them to think about and know what to expect in their labour. As argued in Chapter 10, their experience of control in labour is shaped to varying degrees by maternity staff, baby, nature and the women themselves.

8.1.2 The place of birth

Contrary to recent studies cited in § 4.2 and §5.2, the women in this study felt that childbirth was safer in hospital than at home. The preference for hospital delivery was suggested by all mothers from both groups including the six second time mothers. Only one Scottish primigravida indicated that she probably would like to have a home delivery for her second child if her first childbirth was normal.

All mothers interviewed felt that they had more confidence in technical competence and professionals' assistance in hospital than at home.

Because hospital has medical cover and equipment (Wh).

... because it is safer in hospital. You can have more people to help you, for example, doctors and nurses (W6).

Even the second time Scottish mothers resisted the comfort, familiarity and apparent safety of home delivery.

Hospital for me and it gives me confidence, you know. If anything goes wrong, help is there. And being at home doesn't hold any particular attractions for me and I do not, ... I certainly had no confidence at home. It's no doubt. When I was in early labour with my first child, I spent most time at home. I was literally at home until six to seven centimetre dilated, so I stayed at home for most of it. That's lovely but I am very glad I didn't stay at home for all of it, because it would be a shocking mess. If it could go on for many hours, there wouldn't be a doctor able to come as quickly for Ventouse delivery as it happened in the end. There just wouldn't be this a kind of factory line set-up of people, you know, having three in the end taking the baby off me, just reminding me and in a second my body was covered. You get that in hospital but you don't get it at home. I'm a sort of amazed at the advantages of the comfort, safety, familiarity and so on of being at home but I am quite happy to trade those things for some extras (Wc).

The second time Chinese mothers felt the same.

I think hospital is the best place to have my baby.... It would be more convenient to have my baby in hospital than at home. Though they can bring everything they need to my home, it is still not very convenient (W7).

Home delivery was not convenient for her because W7 already had a nice house and she did not like to make a mess of it. In addition she felt uncomfortable to have her eight year old son around during her childbirth. She preferred hospital to home because of the above factors and the unpredictable nature of labour.

From the safety point of view, hospital is a better place I still feel this [home delivery] is impossible, despite the knowledge that I know they will come to my assistance. I've never thought of giving birth to a child at home. There are too many fears (W8).

The women's attitude towards hospital birth from both groups was based on their fear of the uncertainty regarding the progress of labour. One woman suggested Domino (§5.3.2) was good for having the first child but not the subsequent one.

If I did have my first baby, I would have been interested in it (Domino). I wouldn't do it now. One of the things I want to manage well about the second stage of delivery is, first, I want to ensure it is as comfortable as it can be with my absence [from home] and, secondly, I do want to make sure I have some time to fall in love with the second baby without being prompted, when she is born (Wc).

She was fully aware of medical preference for Domino deliveries of second babies because they knew the women's general obstetric history and the second childbirth tends to be shorter and easier. But what she wanted was to be away from home and to have some time to get to know the newborn and not the early discharge.

Although the demand for home and Domino deliveries increased, all mothers in this study happened to be in favour of the hospital delivery. Home delivery and Domino still did not hold much attraction for them because, first, the women feared some unforeseen difficulty might happen during their birth; second, these services were less publicised; and finally they were thought inconvenient for the older children. The women appeared to have been convinced that hospitals had been set up to help them facilitate and control the process of childbirth (Evans 1985). To some degree their fear and anxiety about the uncertainty of childbirth originated from and was influenced by the current medical practices.

Hospital birth has moved childbirth from a private domestic sphere into a medicalised public sphere. This altered social expectation and experience of hospital delivery remains a dominant feature in the women's perception of childbearing. The women felt that they could have better pain control in a hospital setting as it is a safer place than home for administration of intravenous analgesia and anaesthetics. This may be a reflection of the fact that the majority of the women were recruited from hospitals and also that labour pain is a reality to them while maternal or fetal mortality is only a possibility. It may also reflect the continuing influence of the dominant medicalised childbirth culture in Scotland. This implies women's faith in the medical system, that if something goes wrong, obstetric control of childbirth is there to help control events. This also indicates the mutually exclusive relationship of women's personal and the obstetric control of childbirth. What they wanted is the total control of the whole process of childbirth and it may not necessarily be unaided control of it.

8.1.3 Partner's presence

The couple's emotional experience of childbirth has been attracting more and more attention recently. Since the late 1960s the presence of the partner has gradually become an integral part of childbirth practice for both Scottish and Chinese mothers in Scotland, intended to reclaim birth as a positive experience (§5.3.2).

There were five choices of a birth companion offered in the birth plan in the maternity hospital for social support in this study: the woman's partner, mother, relative, friend and midwife. All women in the study chose their partner to be their birth companion. This may reflect the present family structure and general Scottish social expectations.

Half the Chinese women expressed their preference of their own mother or mother-in-law present during childbirth rather than their partner on the ground that

they were more empathetic and experienced. However, all of them chose their partner for their primary social and emotional support in practice because of the absence of their mother or mother-in-law.

The presence of my mother and mother-in-law would be much better because they have experience and are more ready to help. They can look after me with greater sympathetic consideration. The husband is more careless (W9).

The presence of her mother and mother-in-law was regarded by W9 as not merely physical presence but a more effective emotional support and physically comforting because her mother and mother-in-law were thought to have first hand experience and were able to understand what was going on in labour. As an ideology half the Chinese mothers expressed their wish to have their mother or mother-in-law present instead of their partner.

I feel the presence of a woman is much better than a man. Perhaps my partner is too familiar to me and makes me feel embarrassed. Perhaps he has to be present as I have no relatives or friends around (W4).

In addition W4 made a further distinction between mother and mother-in-law. She repeated on several occasions in the two antenatal interviews that she preferred her natal mother or natal sisters rather than her partner's mother because her natal kin would try to help and protect her interests rather than the interests of the new born, the descendant of her partner's family.

I really hope to get help from my mother or my own sisters (W4).

I really hope somebody who is blood related to me will be present at birth, for example, my parents or my sisters. ...I feel I need that kind of emotional support.... I am not sure whether it is because of living in a foreign land, this kind of need I feel stronger than ever. ... If everything was handed over to the hands of the parents-in-law, the decision would definitely be different. In my view the child is a member of the in-laws' family. Daughter-in-law may not be the member of her husband's family (W4).

I trust only those blood related relatives like my parents are the best birth companions (W4).

W4 is a social science academic specialising in women decision making in south-west rural China. She used a Chinese traditional view that she knew well but that did not necessarily express her personal view. However this represents some Chinese traditional Chinese women's view in general (§3.1.4, §3.1.5, §3.3). Her comments suggest a conflict between her interests and that of her baby and a tension between herself and her in-laws. Her reaction towards the absence of her own kin displayed insecure feelings she had toward her mother-in-law and also disclosed the ambivalent position she had in her partner's family (§3.1.5). This reinforces the argument about

the daughter-in-law's inferior position in the Chinese family structure and indicates cultural meanings of birthing as women's business and less emphasis on the birth as symbolically important event in the union of a marriage as articulated by some of the Scottish women. It could also be an area where greater cultural understanding on the part of the hospital staff involved might be beneficial. This issue is expanded in chapter 10.

Though for most, the ideal choice would be to have the mother or mother-in-law as their birth companion, some of the more westernised Chinese mothers felt differently.

I still feel my husband is more appropriate because I feel the child is mine and my husband's. I hope to involve him in it as much as possible. I would like to share the care of the baby with him. I feel this is the first important experience we both can share. As for my mother, I feel I need her during the *zuo yuezi* but nothing else (laughter) (W5).

The statement about her baby being 'mine and my husband's' reflects a western orientation to the nuclear family. A similar expression also emerged from the W3's interview. 'The new life was created by us two at the very beginning' (W3). Both W5 and W3 were married to British men.

The presence of the partner was generally seen by the women in both groups as a great support and a symbol of strengthening the bonding and shared feeling of responsibility. One of the Scottish mothers thought that the presence of her partner

... was a great, great help. Being there is a great help, rubbing my back, encouraging me ... (Wb).

A similar feeling was shared by Chinese mothers. One of them said

I think my husband has played a great role during the birth. When I had pain during the contractions, he helped me to press my back when I did my deep breathing. He helped me pass that difficult time (W9).

Childbirth normally was an event that a couple could never forget. The presence of their partner was a great experience for them. All men attended their partner's childbirth happily in these two groups of women, except the one Scottish man (Wg) who appeared to be rather timid, scared and stayed at the back of the scene.

He just sat at the corner eating (laughter). He must have been nervous (laughter). ... Really he wouldn't come near (Wg).

This case conveys a sense felt by her partner of some social pressure and social obligation to be present at the woman's childbirth.

Although some Chinese mothers would have liked to have their partner present at their birth, they were not sure that their partner would be there because they were in the catering business. In their view, the partner's job was their family's bread and butter and so more important than their own childbirth.

My husband. If he is too busy, may be my friends. But I don't think they are free either. I think I will be on my own in my labour (W7).

This woman expressed her wish for her husband's presence. In the end her husband managed to be with her during the labour. Her testimony reflected an image of an ideal good wife according to the code of her culture (§3.1), who was supposed not to make any great demands on her husband but to support him and put the interests of her family first. It was up to her husband to prioritise whether he would be present at her childbirth.

Another Chinese woman expressed similar reticence about her husband's presence though she had chosen him to be present because of the absence of other relatives near by.

In fact I am quite afraid of him, because in China, no man is present at his wife's birth. He appears more anxious than me. He is more timid than me. He asked me not to make too much noise when he is there and not to pull his hair and embarrass him. I asked him not to get angry with me (W8).

She thought the presence of her husband might make things difficult for her. She worried about being disgraced if she lost control because of labour pain and made noises. She was apprehensive that her husband might get angry with her by illustrating the contrast between the pain of childbirth and the pain of having his hair pulled. Both she and her husband reached an agreement to maintain a certain degree of self-control. This highlights not only the implicit subordination of the wife's needs to the husband's (§3.1.1, §3.3), but also how important self control and 'face saving' (§4.2.4) is for men and women alike in Chinese culture.

The presence of the partner among Chinese mothers seemed to be more frequent than those in China. This study suggests four reasons: (1) the absence of the extended family due to immigration and/ or immigration control; (2) predominant pattern of nuclear family structure of the Chinese in Scotland; (3) the pressure from midwifery staff in the form of their request or expectation as a response to the presence of a language and cultural barrier; and (4) the Chinese women's readiness to accept the current practices in Scottish childbirth culture.

If there is a language barrier, we actually encourage the partners to be present They have a problem again. They are in a restaurant business. ... They

can't get time off work when the woman goes into labour. The men did not see it was relevant for them to be present. They weren't keen to see the baby being born If they [partners] were not there, we tried to get a female member of the family to translate or act as a go between (Pd).

Again it is interesting to see this midwife unwittingly promoting the presence of the partner — not realising this is not a cultural norm for Chinese women. It is also worth noting that the midwife did not see women's family members or friends as the first choice — when this might be preferable for many Chinese women. Pd's quote illustrated well the professional's reaction to the absence of the Chinese fathers and their reliance on the men's assistance in their communication with the women. She also revealed her resentful feeling in a way at the absence of the woman's partner and at the increasing difficulties in communication in her work as the result of it.

The language barrier has long been identified but has not yet been adequately dealt with (CRE 1987, 1988, §6.3 & §6.5) as a problem for the Chinese when they seek maternity care. Neither partners, relatives nor interpreters are the best solution to this communication problem because most of them had no medical background and did not quite understand the routine of the hospital and medical jargon. And there is often no equivalent in another language and the interpreter has to rely on his or her understanding and elaboration. One Chinese woman phoned me at home many times to ask me to be her midwife. Her desire of using a bilingual professional rather than a professional interpreter (Schott & Henley 1996: 89-99) appeared to be a better way for her.

The presence of the partners was primarily viewed by medical and midwifery staff as a means of enhancing the woman's birth experience and their control over their labour (§5.3.2), but one Scottish woman revealed that the presence of her partner and her mother were, in fact to some extent to help the midwifery staff to calm her down.

Mum was wiping my head a lot ... and Brian stood there holding my hand.
Not a lot they can do (laughter). just to stand and wait. They would keep me calm (Wh).

So there is a reliance on the midwifery staff for the presence of the partner to calm the woman or to interpret for her. This indicates an inconsistency in policy and practice. Though the strategy of having a birth companion is designed to empower the woman, it is also used for the convenience of midwifery staff.

8.1.4 Birthing position

The position in childbirth had been discussed a lot during pregnancy among the women especially in their antenatal classes, although there has been little well-controlled research to assess the validity of various strongly held opinions (§5.3.2). All women from both groups found that they had to be confined to semi-upright position on the birthing bed and did not have much choice as the result of the complications of labour or the need of continuing fetal monitoring because of their choice of analgesia.

One Scottish woman expressed her ideal birthing position before her childbirth

I'd rather keep active right up to the very end. I don't want to lie flat on my back. I don't think. Gravity helps. I'd be a sort of sitting up or supported or whatever. I'll see what's most comfortable I suppose (Wb).

She was disappointed to find out after childbirth that she had no choice on position because of the dreadful pain she had at the time.

I would prefer to be on my side, I think, but I ended lying on my back, I was more comfortable with [that position] (Wb).

A conflict between her mind and her body was indicated here. Many women found themselves in the same boat: that they had to adopt a position they did not like.

... they asked me if I would mind to turn on my back again because when I went on hands and knees, which was comfortable for me but the baby's heart beats shot up; and they thought it was making the baby distressed (Wc).

I wasn't given a choice in the end because the doctors needed to be able to see what was going on. So my only option was to turn into a position which I didn't want to; which is an object, you know. I was just lying back. I could see nothing. I was covered with sterilised sheets and my legs were in stirrups (Wc).

Even the second time round, when Wc's delivery was straight forward and drug free, she still felt that she had no choice over her position at delivery. Whenever the contractions came, she subconsciously closed her legs at the second stage of labour and the midwives kept on asking her to open her legs and had to use their waists to support her legs to maintain a wide open position.

Another did not make any decision about birth position simply because of the uncertainty of labour.

I haven't really given any thought about that. I don't know. It's difficult to say now because I don't know how I am going to feel (Wf).

One Chinese mother revealed after her birth that

As a Chinese I never heard of any other position of delivering baby. I felt better when lying on my back. I prefer lying on my back. I felt much more comfortable. They told me that I could squat, kneel or sit but I did not like those positions (W9).

Though the free choice of position of childbirth was discussed most often during the antenatal classes, all of them delivered or had their baby delivered in their delivery bed or operation table in accordance with their individual situation. There is no consistency in the findings with respect to the effect of position on the well-being of the baby.

8.1.5 Food

Labouring women are usually advised not to have anything but water in case surgical intervention is needed (§5.3.2). One Scottish woman disclosed

I didn't have anything to eat. I had, I started off drinking Coke then I just vomited right away. So I was advised not to drink anything but water (Wb).

Anyway many women reported that they had no appetite though they felt hungry.

In the first stage of labour I had (a short pause) I was sick at home before I went to hospital. So I was awfully sick with the pain so I didn't have. I had sips of juice but not anything to eat. No I didn't want it. It was the last thing in mind (Wa).

The soup of dry longan pulp (*guiyuntang*) was reported by four Chinese women (W8, 9, 10 & 12) to be used in labour in Southern China to strengthen the labouring mother during the first stage of labour (§4.2.4). However *Guiyuntang* is often not available in the market and is too expensive in Scotland. When those Chinese women from the south were about to be in established labour, they usually did not bother too much about it.

I heard people mentioned *guiyuan* in the past but it is no longer taken by people here now (W9).

They usually had a home-made two course meal (W6 & W8) before they took themselves to hospital. The food they had were rice, egg or meat based dishes

and some soup. They disregarded the medical precaution on food intake and considered there was no need to fast.

... when my mother and my sister-in-law had their babies, they had *guiyuan* [dry longan pulp] and egg to strengthen their *yuangqi* [vitality, vigour or strength] because they had no appetite at that time and could not take in anything. ... I followed what my mother did. I stir-fried five eggs and made some rice and I had most of them just in case the labour would start during the day. I think it depends on what you can tolerate at that time. You can eat anything you can tolerate (W8).

None of the Chinese mothers mentioned 'Ginseng tea' (*shentang*) (§4.3.2, Tsay 1918: 535), dry ginseng (Dunn 1978: 158) and honey water (Yu 1531: 327) that suggested in the literature to be used for the late of the first and the second stages of labour for strength building.

There is a major difference between the Chinese and Scottish women in their approach to food before or during labour. Though both preparations are prophylactic, the emphases are different; one is on childbirth as a normal event and the other is on childbirth as a potential medical emergency. The attitude toward food during labour varies according to their existing dietary habits, their beliefs, traditions, culture and area of family origin. Scottish women follow medical advice, while the Chinese women appear to follow the dietary advice that makes sense to them and disregard that which does not.

8.2 Obstetric technology

The beliefs about and attitudes to obstetric technology were different between Chinese and Scottish mothers. Many people see technology as essential for tackling difficult labours and a key power within the profession and within the doctor-patient relationship. These issues are explored in relation to three types of obstetric technology: obstetric monitoring, interventions (accelerated labour and instrumental delivery) and pain management.

Table 7 gives an overview of the monitoring, accelerated labour, pain relief the mothers underwent during their labour and delivery. The general clinical practices in the maternity units in this study were four hourly assessments of labour progress. These entailed a quarter hourly intermittent CTG or Pinard fetal monitoring, 2 hourly blood pressure and pulse checks, a four hourly temperature and internal vaginal examinations, abdominal examinations and urine analyses to assess maternal and fetal well being and the labour progress. Medical or pharmaceutical delivery refers to the women who received intramuscular (IM) analgesia, epidural, induction and

augmentation of labour by means of application of local and intravenous (IV) drugs. Surgical delivery refers to instrumental deliveries by means of artificial rupture of membrane (ARM), episiotomy, Ventouse, forceps and caesarean section. Intermittent fetal monitoring was usually applied for all straightforward non-medical deliveries and continuing, for all medical and surgical deliveries.

Table 7 Medical and surgical interventions undergone by the women

Case No.	Monitoring			Accelerated labour					Pain relief		Instrumental delivery		
	4h	>4h	Continuous	Induction	Augmentation	ARM	IV Syntocinon	Episiotomy	IM Analg	Epidural/Spinal	Ventouse suction	forceps	Section
W1		x	x					x	x		x		
W3	x							x					
W4		x			x		x		x				
W5		x	x		x		x			x			
W6		x	x		x			x	x				
W7		x		x		x			x				
W8		x			x	x			x				
W9		x	x		x	x							
W10		x	x		x		x		x	x			
W11	x								x				
W12			x	x		x	x			x			x
Wa		x	x						x	x			x
Wb		x	x		x	x	x	x	x	x		x	
Wc1		x	x		x			x			x		
Wc2	x												
Wd	x												
We		x	x						x				
Wf		x	x	x				x	x	x			
Wg		x	x		x	x			x				
Wh		x	x		x		x		x	x			x
Wj		x	x		x		x		x				
Wk			x							x*			x
Chin	2	8	6	2	6	4	4	3	7	3	1		1
Scot	2	8	9	1	5	2	3	3	8	5	1	1	3
Total	4	16	15	3	11	6	7	6	15	8	2	1	4

NB: Wc2 refers to the same mother Wc1, who gave birth to her second baby

* indicates epidural/spinal conducted solely for the elective caesarean section.

Only two women from each group had simple four hourly labour assessments during their labour. Fifteen of sixteen women who had more than routine four hourly assessments, needed to receive constant fetal monitoring because of the changes of their management of labour. These changes were due to either the application of ARM, and/ or IV syntocinon.

The women who had more than four hourly assessments tended to be those who required more pain relief and who had induction or augmentation of labour. As the result of the application of analgesia and acceleration of labour the needs of

continuing fetal monitoring was dramatically increased. The relation between assessments and interventions remained in direct proportion: a higher monitoring rate resulted from a higher intervention rate. The vigilance often led to further intervention. Instrumental delivery was closely associated with increasing interventions and monitoring.

Table 8 Summary of Table 7

Name	Monitoring			Acceleration			Pain relief			Instrumental delivery			
	4h	Con tinu e	Tota l	Indu ctio n	Aug men tatio n	Tota l	IM Anal g	Epid ural/ spin al	Tota l	Vent ouse sucti on	forc eps	Sect ion	Tota l
Chin	2	6	8	2	6	8	7	3	9*	1	0	1	2
Scot	2	9	11	1	5	6	8	5	9*	1	1	3	5
Total	4	15	19	3	11	14	15	8	18	2	1	4	7

*NB: Four women had both forms of pain relief and another four women had no pain relief. Therefore the total is $9+9 = 18$ (Cf. Table 7).

Table 8 indicates 15 mothers in the study received IM analgesia and seven received epidural as a form of analgesia and one for elective caesarean section. Four women received both forms of pain relief (Table 7) and four had no pain relief at all. Eight Chinese and six Scottish women had induction and augmentation of labour by means of either amniotomy, IV syntocinon and/ or episiotomy. Five Scottish and two Chinese women had instrumental deliveries (Table 8). The overall numbers show that there is no marked difference in the choice of analgesia, types of delivery and outcome of their birth between these Chinese and Scottish women.

There was a range of different attitudes towards obstetric technology among the women. Scottish women preferred painless labour as what they stated 'As pain free as possible. As short as possible' (Wb). A Chinese woman believed

The technologies of painrelief, amniotomy and acceleration of labour are the things for the Scottish. We Chinese women are different (W9)

In her view, Scottish women were used to expecting a certain amount of technology in their labour because their focus was more on how they felt rather than what effect those interventions might have on their babies. Implicitly Scottish women were seen as less selfless and less stoical than Chinese women.

By contrast an obstetric consultant of Chinese origin in Scotland reported that

They [the Chinese] tend to want even more interventions because they really believe that the solution to everything else in this world is technology (P2).

This obstetrician's vision implies that women's reliance on birth technology is a natural outcome of the mechanistic view of the body by which it is seen as an imperfect machine whose efficiency can be improved with other machinery.

Their [Chinese] wishes tend to be very similar to the local [Scottish] people. ... Chinese women ... usually want the technology. They tend to think of things in a more practical way rather than, you know, a cultural religious influence is not a such a big issue. ... They tend to ask for caesarean section. They tend to ask for intervention. They like monitoring and so on. They tend to like pre-natal diagnosis (P2)

A similar testimony came from P1, a professor and consultant obstetrician from Shanghai. Caesarean section was welcomed by primigravidae in China. The caesarean section rate in some hospitals in Shanghai was up to fifty percent of total deliveries in 1991 and 1992. The expectant couples believed that caesarean section could prevent their baby from having birth trauma and the operation was short, pain free and easy for the mother to recover. The story of a lecturer (F1) from Beijing supports these two obstetricians' claims. She had gone to great lengths in order to get a voluntary caesarean. She thought that at the age of 33 she was too old to have a normal delivery and a caesarean would offer her a painless delivery and a better body shape. The use of caesarean to her was a way to remain in control over the whole process of childbearing and childbirth (§1.4.2, §10.4.2).

A similar theme emerged from the four women from Taiwan (W2, W3, W5 and F2) all of whom reported that the caesarean section rate was very high in Taiwan. Caesarean sections were frequently used as a means of ensuring that their child would be born at the right time and moment for the luck of the child after their consultation with a religion practitioner.

8.2.1 Obstetric monitoring

Fetal monitoring and labour progress monitoring are routinely utilised in hospital-based deliveries on the grounds that these practices help to ensure the lowest maternal and perinatal mortality rates. The evidence on this, however, is contradictory (§5.2). They tend to be used extensively in cases with complications. Fifteen out of sixteen women had continuing fetal monitoring soon after their acceptance of either IM analgesia, epidural, augmentation of labour or other forms of intervention. Constant monitoring often leads to early detection and results in intervention. This seems to suggest and support the theory of cascade of intervention (§5.2.1, §5.3.2).

The technology of fetal monitoring was not only reassuring to the doctors and midwives but also to the mothers (§5.2.1). Though most of them did not like the

intervention of monitoring technology, they expressed their appreciation of the reassurance by the practices of CTG fetal monitoring because it provided the information that the baby was alive. One Scottish mother said.

I thought it was - in one way - reassuring when it was on going. But otherwise I felt that you deadly focused on - CTG, once it was there (Wa).

This woman revealed that she was very much preoccupied with the CTG monitoring. She contended that the machine could give her early warning of intrauterine difficulties (§5.3.2).

Westernised Chinese women, like most of the assertive Scottish women, actively sought out obstetric technology, while the less westernised Chinese women were ready to accept what was on offer on the assumption that medical staff know best. These women indicated on many occasions that it was their privilege to have these technologies around and it would be stupid not to use them, if there was a need felt for them. This was particular true in the cases of W5 and W12.

One Chinese mother (W7) with little English had a straightforward delivery. She revealed 'They did CTG monitoring many times but they didn't explain why'. A Scottish woman (Wg) did not have any explanation about the monitoring, either, though she thought she knew why she was monitored.

Just for a little while. ... I'd been monitored because I was late [for dates]. ... So I knew what it was about (Wg).

Sometimes the monitoring was thought unnecessary, but some Chinese women did not question the professional decision and took it as what was meant to happen.

They kept the belt of CTG on all the time since I got onto the labour bed. It did not appear to me necessary.... (W9).

Although W9 felt quite uncomfortable with the continuing CTG monitoring, she tried her best to comply with technological culture in childbirth. Similar experiences can be found among Scottish women

It is very uncomfortable, I think, I'm not too sure if it is necessary to check how far you are dilated and whatever, you know. I think it is managed quite well. ... It was a bit invasive (Wb).

8.2.2 Accelerated labour

Labour is clinically accelerated by two methods: induction and augmentation of labour. The method of induction of labour is used in the cases of low levels of uterine contractility and augmentation is used in the cases of slow progress in labour. Induction of labour is usually achieved through topical use of prostagladins gel to prime the cervix and then early amniotomy and/ or the IV administration of uterine stimulants such as syntocinon. Augmentation is achieved through amniotomy, IV syntocinon and/ or episiotomy.

The labour of all seven Scottish primigravidae and four Chinese primigravidae in the study progressed more slowly than expected and ended up with intervention of one kind or another.

... the first time you don't know what to expect and your body is slow. My body was slow (Wa)

It has become a routine that these technologies are used just 'in case'. The most usual means to achieve such efficiency is amniotomy or ARM (§5.3.2). Four Chinese and two Scottish women in the study had amniotomy, which is thought to reduce the length of time in labour; it also makes it possible to observe the colour and amount of liquor for any early signs of fetal distress and allows for electrode onto the baby's scalp for continuous fetal ECG monitoring to record the strength and frequency of uterine contractions and fetal heart rate. The application of ARM increased women's experience of pain and led to further investigations and monitoring.

I had to lie flat on my back because they broke my water and it was meconium stained so they had to put a probe on his head, take blood from his head and I was strapped up to the CTG machine. So I couldn't move ... They wanted to keep an eye on his heart rate as well. 10 mg diamorphine had clouded my judgement. I thought I was rather small, 10 mg; that is big. It certainly took the pain away, knocked me out at that point (Wb).

At the end her baby was born with Apgar¹ only 3 and 7 with a Kielland's (mid-cavity, rotational) forceps delivery. Her dissatisfaction was put down by herself to the diamorphine that she received, which clouded her judgement. She believed that her

¹ Apgar score is assessed at 1 and 5 minutes after birth. This involves consideration of five signs: heart rate, respiratory effort, muscle tone, reflex response to stimulus and colour. The maximal score is 10. If the score is less than 7, medical aid should be sought. It indicates a different state of asphyxia neonatorum. Apgar score 4 or below indicates the baby has circulatory collapse and is therefore shocked.

choices and her birthing experience would have been different if her judgement had not been clouded by analgesia. She may not have realised that the use of ARM may increase her need for more analgesia and epidural because of the increasing intensity of contractions and the anaesthesia may relax perineal muscles and then interfere with fetal rotation, decrease the infant's ability to rotate and cope with stress and disable her from pushing, therefore the forceps delivery becomes necessary. In this way she was socialised into being dependent on medical aids. As the result of this she felt that 'the control was taken away from me' (Wb).

Three of the four Chinese women who had ARM reported that they did not have any explanation regarding the procedure. One of them assumed that she knew what it was for and the other two did not give any indication of their intention to ask why ARM was required. Four possible reasons are suggested here on the silence of Chinese women: (1) their unfamiliarity with environment and routine procedures; (2) their dependency during labour on the midwifery staff; (3) their culture's obligation of compliance; and (4) the presumption that medical and midwifery staff knew best. Though the Scottish women had similar problems of unfamiliarity with environment, dependency on the medical staff and presumption that the medical staff knew best, the Chinese women experienced a further degree of these problems and placed much of their reliance on the professionals because of language and cultural barriers.

The possible reasons from midwifery staff's point of view not to offer Chinese women an explanation on ARM were (1) inability to speak Chinese and uncomfortable to explain in English on the assumption that their explanation may not be understood; (2) the uncertainty of the women's reaction; (3) the assumption that it was too common and the women already knew or they did not want to know.

Four Chinese and three Scottish women had IV syntocinon infusion (Table 7). Coincidentally two of the three Scottish women had IV syntocinon prior to the insertion of their epidural so they reported a more negative feeling toward it and felt that an epidural was needed to help them cope with their pain. Chinese women did not mention syntocinon infusion at all. Their indifference to it was the result of three of the four having epidural in situ prior to the administration of IV syntocinon. The increasing uterine contraction pain caused by the drug were completely cut out by the epidural. The only Chinese woman who did not have an epidural was given diamorphine but had no knowledge of receiving it.

I am not sure if the intravenous infusion was normal saline or something else. I was told that my cervix opened very slowly. So they said they were going to give something to assist cervix dilatation. ... They could not explain that to

me, because I felt so sleepy after that injection. ... What I remembered was that infusion was to help cervix dilatation (W4).

All the women in the study did not want to have an episiotomy² if possible but three women from each group had it. Three of them had a strong objection to it. Two had it with no choice, the other had a second or third degree tear with her objection to episiotomy respected. Retrospectively she regretted that she had not chosen an episiotomy.

I got such a bad tear. ... In fact it would be better to have a cut done so the labour could be finished quicker and the tear could be minimised or directed to the right direction (W8).

In comparison all those who had an episiotomy thought that it took them longer to return to their normal life pattern than those who had not.

I was torn so badly [after an episiotomy for Kielland's forceps delivery]. I got a scar of that length [5-6 cm long gesture]. ... I could hardly walk for about a week. For a week I took my dog to have a walk, it took me three times as long as normally (Wb).

On the whole the majority of the women were not aware that the acceptance of any form of acceleration of labour would entail future intervention including continuing CTG fetal monitoring, more frequent labour progress assessments, interventions such as ARM, IV syntocinon, episiotomy and/ or instrumental deliveries. Or at least they did not give any indication of their understanding of the implications (§8.1). The awareness of this cascade link of acceptance of acceleration was particularly vague among the Chinese women as they were less familiar beforehand with hospital procedures.

8.2.3 Pain relief

The experience of pain stands out in my interviews with Scottish women, but less so with the Chinese women although there was no marked difference in the use of pain relief (See Table 7). Scottish women on average spent one fifth of all of the third interview time in talking about their experience of labour pain while Chinese women just mentioned it briefly.

There was a marked contrast between Scottish and Chinese women in their approach to pain relief. The Scottish women spent time and energy before the birth on

² Episiotomy is an incision made into the thinned-out maternal perineal body to enlarge the vaginal orifice and accelerate delivery to avoid intracranial trauma to the fetus, overstretching, or undue damage to the pelvic floor of the labouring mother.

selecting suitable methods of pain relief for themselves, while nine out of ten Chinese mothers opted not to choose any drug for pain relief until they had to; 'wait and see' was their favoured option. This open choice may also relate to their lack of information and their fear of the side effects of analgesia and/ or anaesthesia because western medicines are seen as 'hot' and therefore potentially dangerous for the baby (§3.2, §7.6). Most of the women from both groups felt their lack of first hand experience of using the analgesics.

One Chinese woman (W8) was surprised to find out that she could have a choice on pain relief. Another felt so grateful that 'I have never received this kind of good service (W4)'. This reveals a big difference in social expectations between Chinese and Scottish women. In China Chinese women are expected to experience labour pain. When they are in Britain, they are surprised that pain relief agents are available for choice and the NHS service is there as a service to help them. This makes a contrast to the Scottish women, who all felt they had a right to this kind of service.

Since she had never used any pain relief in her previous labour in China, W8 thought anything this time would be sufficient for her to cope with her labour pain.

I feel since I have never used any analgesia or other methods in my previous childbirth, once I can get something, it will be a great help to me (W8).

Her decision of accepting analgesia indicates that making a choice is closely associated with the cultural expectation and the situation she was in. In China analgesia was thought harmful to the fetus, therefore she was deterred by those beliefs and practice from using it in her previous birthing experience. Changing a social and cultural context led to a change in her attitude towards the drug used in labour despite her fear for the safety of her baby compounded by the side-effects of analgesia or anaesthesia. The compromise she reached was to receive one analgesic only, though she regretted retrospectively that she might have had a better experience if she had received more or stronger pain relief.

The description of pain tends to be related to the emotional constitution of an individual and her preparedness and awareness of what is in store. The following reveals how labour pain can be compounded when a woman is traumatised as the result of medical intervention.

I suppose anything is bearable if you can control it, you know how final it will be. I think at least part of it I find so excruciating because I was panicky, because I had been led to expect that would end soon and far from ending soon, it just got worse and worse. It just seemed no end in sight. I am sure had I, had, if anybody or anyone would be able to give me the gift of the fore-

knowledge that I would be in for two really, really, really hard hours, I probably could pace myself better; or probably at minimum I might be in as much pain as it was I certainly would not be panicky, which made the pain absolutely unbearable (Wc)

If knowledge of pain had been provided, the intolerable pain might have been reduced to a bearable range. The psychological state of women can influence the perception and tolerance of pain. The level of pain tolerance can be retrained within a bearable range, if the pain is integrated into a meaningful system (§4.2.4, §5.3.2) and/ or according to a health worker, if the women felt that they were in control.

Pain in childbirth is endurable when there is an end product to it. And you do get rest in between contractions and that's helpful (Pa).

This further supports the claim that 'Culture makes pain tolerable by integrating it into a meaningful system' (Illich 1975: 93).

The perception and tolerance of pain are also culturally oriented.

I don't know if the Scottish women were quite as tolerant toward it [pain] as the Chinese (Pa).

Chinese, very often they never consider pain relief as such, or they don't know what is available to them, or culture wise, pain relief may not be normally used (Pd).

Bearing pain is part of femininity in family building in Chinese culture (§4.2.4). It is a complicated reaction to a pain stimulus and mental state of an individual. Though pain relief is a known option for Chinese women in Scotland, they worried about the side-effects on their babies and would prefer not to use it if they could.

It seems to me there are quite a lot of side effects, and everyone is different. It's difficult for me to decide. I think I would not use it at first. ... You know one of my friends told me she tried to postpone epidural request again, and again and eventually the water broke and she delivered her baby within four hours and did not use it (W6).

The relationship between stress and self-control is defined by the pain control experience of a woman, her personal characteristics and her cultural background. The desire to be 'in control' (§1.4.2) and not to 'lose face' (§4.2.4) influences and encourages the acceptance of pharmaceutical assistance among Chinese women and Scottish health workers alike.

... a lot of doctors I know and midwives I know, would opt for epidural, would not opt for without it because they do not want to lose control. They don't want to be seen being shouting, and screaming, and don't feel that when they are in that much pain, they might lose a bit of dignity. I thought that might be quite interesting, people want to take epidural so they could stay completely in control and that is what it does for you (Wa).

The coping strategy illustrated here is different from the Chinese concept of control (§4.2.4), in which the control is mainly achieved through suffering the pain silently. The quote above also suggests the desire of being in control induces stress. This stress can also be found in the anxiety of W8's husband who did not want to be embarrassed in his presence by his wife's loss of self-control (§8.1.3).

There is a range of strategies for coping with labour pain among women from all classes. One health worker suggested that women of lower social classes in many respects seem to get on with their control well by being quiet and higher classes tend to be noisy.

... higher social class are more noisy. They are less, perhaps less tolerant of pain; because they are scared of making fool of themselves (Pa).

From my personal observations and experience, the overt noisy strategies suggested by the midwife manager (Pa) are used as a form of coping and a form of acceptance of pain. This way of coping may sometimes confuse the health workers who are looking after the women, because they are more likely to interpret this as a signal of suffering in the light of the knowledge available to them, and they are more likely to offer analgesia or anaesthetics as an appropriate response to these cues given by the women. The noisy women tend to be offered more analgesia than those who are quiet in the interests of a quieter labour ward environment.

The midwife manager with experience of looking after twelve Chinese women and their deliveries further commented

Westernised people wouldn't suffer quietly but they tend to suffer noisily. I found the Chinese women I encountered suffered quietly. It's not that they were not suffering. They were experiencing pain but I felt they endured that pain with great courage (Pa).

Another senior midwife has experienced the reverse.

To be honest I don't like to look after Chinese women, they are too noisy (Pc).

It seems that this midwife's experience of Chinese women was unusual. There were quite a few indications of this mismatching Chinese women with other Asian women in the interviews with the midwifery staff. Being noisy during labour is not part of their cultural coping strategy. From my previous job as a barefoot doctor, the impression I had was that some expression of pain was tolerated during the childbirth in Chinese culture but not persistent or hysterical screaming and crying. Any woman

who behaves this way is likely to be reminded of the shame that she might have to cope with after the birth.

One Chinese woman commented that suffering pain quietly was unhealthy and many women could not always behave in a rational way despite the presence of mounting social pressures on them.

If you suffer the pain silently and don't make any noises during labour, you may feel you are not normal, because you have lost the normal reaction to those biological labour pains (W8).

None of the Chinese women in the study thought the fear of losing face or self-control was related to birthing directly. They denied having the feeling of shame as 'childbirth is a natural event in family building. It has nothing to feel ashamed of' (W3, 4, 7, 8, 9) (Cf. §4.2.4).

In coping with pain eight Scottish women appeared to have adopted a relatively more assertive approach than their Chinese counterparts

I had just gas and air. I used breathing technique with the gas and air. And I moved around as much as I could. I got out. The midwife kept on saying 'Good girl' you know, because I was up, you know. I felt better that way. I don't remember being (a short pause) painful so much as uncomfortable. Yes it was painful but it wasn't the sort of pain I felt it (another short pause). I can't quite explain it. It wasn't, it did not occur to me to ask for a shot of diamorphine at that point. It just never crossed my mind. I thought 'This is it. This is what it is about what I am doing.' (Wj).

Being in control or appearing to be in control very often leads to less pharmaceutical and surgical interventions because the attending midwives tend not to offer analgesia as often as when they attended a woman who appeared out of control. They tended to associate quietness with being in control and noise with being out of control.

I think, if you appear to be having a controlled labour and appear to have a high pain tolerance, I don't think you need analgesia perhaps as acutely as someone who is not responding well. And I mean I often joke with my colleagues and said if I ever came in, I would not be quiet. I'd be noisy because you get no reward for being quiet (Pa).

Most women indicated that midwives in general give them a choice in the methods of pain relief but many of the midwives tended to encourage them to accept drugs and epidural by telling them that they would be free from pain and ensure them that it would not harm the baby in any way. Many evidences suggested women's awareness of the implication of side-effect of pain relief but not so much about the cascade effect of pain relief that may increase augmentation rate of labour.

I think the diamorphine totally zonked me. The fetal heart tracing became very flat so I had to get the monitor on all the time (Wb).

The constitutions of people are different. Although there is no doubt that many different forms of physiotherapy, psychological therapies, pharmaceutical therapies or other alternative therapies have a powerful effect on pain, none can abolish pain or discomfort totally. There is a limit to each therapy because people's reactions to pain are individually constructed in different cultural settings and because the pain is an inevitable part of the birthing process. They have different interpretations of the meaning of pain. In most situations people have to compromise and accept whatever alternative is available to them at the time.

The birth was much harder than what I thought it would be. ... It was quite a traumatic experience. The pain I wasn't fully prepared how bad it was. ... Afterward I didn't want to have anymore children (Wb).

This previous pain experience shaped a woman choice for her subsequent birth.

General anaesthetics at the front door (laughter). ... I would be MUCH keener, I think, to accept drugs quicker ... (Wc).

Though her experience of trauma was extreme, her mental state of fear of pain and readiness of acceptance of analgesia to some extent was shared by at least half the Scottish women. Fortunately her second delivery was drug free and quick.

So actually once again, against my will, I have this drug free delivery. The second time, I wasn't that kind of scary. I wasn't that kind of stricken, I suppose so ... I am not saying in retrospective I am delighted to have no drug (Wc).

Pharmaceutical therapy or anaesthetic therapy appeared to be the first choice for some Scottish and some of the more westernised Chinese mothers in the cases of W5, 10 & 12, who chose a pain free delivery with an epidural.

Pain is a recognised and expected part of the birthing process in both cultures. The interesting thing here is the degree the pain displayed and dealt with. In about a hundred, mainly home deliveries that I attended in China in the 1970s, women did not use any analgesia to help them to cope, because they believed that medication would do more harm than good to their babies. It was unacceptable to use analgesia of any kind routinely during a normal delivery. These deliveries included 7 primigravidae, 3 twins, 10 vacuum extractions, 4 breeches and 1 internal version and extraction (transverse stillbirth) deliveries. This cross-cultural comparison clearly illustrates that the use of analgesics and anaesthetics varies with the local obstetric practices. Even now it is unacceptable in most parts of China to accept analgesia

during a normal labour. According to three well qualified Chinese medical university postgraduates in UK universities, even the urban university teaching hospitals (e.g., Shanghai, Wuhan and Chengdu) were very reluctant to use any analgesia for a normal delivery.

Different cultures have different social attitudes towards pain. In China it is accepted that this pain is part of being a woman. The Chinese women in Scotland have inherited this cultural expectation, but also accepted some Scottish attitudes towards pain and pain relief. They were reluctant to ask for analgesia but they would take it if they felt they were at the verge of losing self control. Different social expectations and life styles foster different tolerance levels to pain and a different coping mechanism according to the situation they were in. Cultural aspect and individual difference of pain management may be the pointer to future understanding and management of pain. Some obstetric monitoring, intervention and instrumental deliveries can be avoidable.

8.2.4 Instrumental delivery

Instrumental delivery refers to vaginal delivery by forceps, Ventouse extraction and abdominal delivery by caesarean section. Seven out of 22 cases (=31.8%) had an instrumental delivery: one forceps delivery (4.5%), two Ventouse extraction (9.1%) and four caesarean sections (18.2%). This compares with the national average of 28.8% surgical intervention in Scotland (forceps 7.2%, vacuum extraction 4.1% and caesarean 17.5%) in 1997 (ISD NHSS 1998: 7). Some women felt a greater control and self empowerment with instrumental delivery than they would have if left to nature. Some had mixed feelings about these interventions.

I know perhaps I could have left my baby, who may have come out vaginally. I am thankful not to have to take the chance of a hypoxia³ [flat] baby ... and thankful the interventions are there. I had a straight forward section. The baby's Apgar is nine and ten, rather than being in a desperate situation, which could have been there (Wa).

Because of her positive experience, this woman had no emotional problems in accepting this emergency caesarean section.

Instrumental delivery was highly in demand among the westernised Chinese women according to a male Chinese obstetrician.

They [Chinese women] tend to ask for caesarean section. They tend to ask for intervention. ... To me childbirth has never been a big issue, certainly to none

³ A diminished oxygen tension in the body tissues.

of them [his sisters]. One of them had an elective caesarean. She insisted having it because she didn't fancy giving birth, full stop. She knew she wanted two children. That's it. She was sterilised after the second (P2).

The only sectioned Chinese woman felt that

Having a section is a mere trifle. [what's more important is she has a healthy baby] (W12).

In the case of Wb (see Table 7), active medical management of labour led to a cascade of intervention: ARM, continuous monitoring, Diamorphine, IV syntocinon, epidural, fetal distress, fetal scalp electrode monitoring, fetal scalp blood sampling and then episiotomy and forceps delivery. The experience of this chain effect in the active management of childbirth was reinforced by the traumatic and undesirable mid-cavity forceps delivery and shoulder dystocia.

I just felt I didn't get to see him, because his Apgar was so low. ... I wasn't allowed to say hello to him, he was whipped away. I felt that I missed out. ... The birth was much harder than what I thought it should be. It is the worst as it can be because he was in a wrong position. He was in OP position. It was quite a traumatic experience. ... Afterward I didn't want to have any more children (Wb).

They didn't give me a choice. They didn't give. They just did it (Wb)

The repeated expressions of 'didn't give' conveys her surprise and anguish.

I was just wanting a natural childbirth, no intervention, ended up with almost everything. But as long as the baby is all right, the end result is the important thing (Wb).

The safety of the baby balanced her negative feeling between her expectations and what actually happened. The similar cascade of interventions can be found in the cases of W12, Wa, Wb and Wh.

Different people have a different experience even with the same instrumental delivery despite the same outcome of having a healthy baby. Their experience is shaped by their circumstances, their attitude towards birth, medical staff, and their expectation. Some women were happy to let the medical staff take control while others were not. The whole picture illustrated a tangible relationship in term of 'power' and 'conflict of expectation' between the women, doctors and midwives, which is further discussed in §8.3.

8.3 Obstetricians/ midwives/ women's relations during the birth

The hierarchical organisation relation between obstetricians and midwives is and has been a common pattern in maternity care in health services. This relationship has reinforced the dominant-subordinate roles between the professions. Doctors have been able to exert more power than the other health workers (Tew 1995). Technical knowledge and skills are a source of power (§5.2). The midwives and the obstetricians have a monopoly of medical knowledge and skills. They control the progress of labour when they decide what information to divulge as well as what treatment or intervention to give to their patients. To control or deny knowledge or access to the labouring mothers is to deny them the possibility of controlling their own birthing process. The power relation between the labouring mothers and the professionals is unequal; although the labouring women and the professionals rely on each others' knowledge. The health workers rely on the women's obstetric histories and the reports of their signs and symptoms, and the women rely on the professional's interpretation of all that information. The extent to which doctors and midwives rely on women's knowledge warrants further discussion.

All Scottish women expressed positive feelings towards midwives. Their dependence for information, training, physical and psychological care during pregnancy and childbirth was especially marked for the primigravidae, who perceived midwives to be their allies, to be with them to meet their needs in their birth.

The midwives were absolutely wonderful at keeping you informed about everything happening (Wj).

The presence of midwives at their birth was more welcomed than the presence of a doctor, because their presence to Scottish women conveyed a sense of 'normality' and reassurance, where the presence of a doctor implied an abnormality and a possible intervention or an instrumental delivery. '... the doctors are brought in only when things get hard' (Wc).

This implicit association of normality with the midwives and abnormality with a doctor reflects an understanding of the institutional division of labour between doctors and midwives. Many testimonies collected in the study suggest that few of the Chinese women understood the different implication between the presence of

midwives and doctors in Scottish childbirth culture. Nine of ten Chinese women placed much more reliance on obstetricians than midwives on the basis that obstetricians were considered the better trained specialists.

If a specialist in obstetrics told me that my fetal position is fine, I would feel much more at ease (W4).

Chinese women did not associate doctors with medical problems but with privilege and prestige and a better quality of service, because

Having paid more money to obstetricians you have better social status. It is very much materialistic (P2).

Doctors were seen by most of the Chinese mothers as more familiar with modern technology. This attitude towards doctors was particularly true among the Chinese women from Singapore and Malaysia according to P2, a Chinese health worker in Scotland.

'Changing childbirth' as a document will never go down well in Singapore because what the women want is to see the doctor. They don't want to see the midwives (P2).

The hierarchy of status between doctors and midwives complicates their relationship and clinical decision making. Their professional conflict may hamper the labouring women's confidence and trust.

They [The labouring women] tend to err on the side that obstetric staff knew what they doing. What they were doing was necessary. They are quite happy to accept it (Pd).

A midwife manager had similar feeling that Chinese women are more compliant with hospital routine and medical authority.

They [Chinese women] appeared to allow the professionals to take charge and understood what was meant to happen (Pa).

The quotes above are very revealing on the one hand about the professional staff's perception of the stereotype of Chinese women, on the other hand, they reveal the ignorance professionals had toward Chinese women. Chinese women are a group of diversified peoples. Some educated and westernised Chinese, like the majority of Scottish women, are trying to be assertive and maintaining their control over their bodies.

One Scottish woman had a surgical delivery after two hours strenuous but fruitless pushing. In her case the doctor had to come in and the midwife had to move aside for a Ventouse extraction to be conducted. The experience she had was

traumatic, and suggested to her that some improvement was needed in the way that doctors interact with women. She felt that the medical staff were inclined to see their patient as obstetric, medical and surgical problems rather than a whole person.

The doctors see it as their jobs to deal with the problem not to deal with the women while the midwives are clearly trained to deal with the women and the whole process of labour. ... If they have some training in, or the process about it, they can pretend to care about the welfare of the women rather than the immediate medical difficulty, it would - in many cases it would make a better experience, not less painful maybe but at least, these doctors faced my bum, I wouldn't have to ask my partner to ask HER what was she doing, you know. She was a kind of manipulating baby's head and was really, REALLY hurting me. I'd been roaring in agony and she said 'Are you having a little contraction?' I said 'No, you are hurting me.' Before she sort of starting on this manipulation, she never said to me something like 'I need to do this because of this, this and this. What I am doing may hurt. That lasts about five minutes then I'll stop'. There was no direction from her as to how endurable or how long any of these interventions were going to last. But she was utterly concentrated on the task in hand. She clearly saw it as the midwife's business to handle that hysterical woman. She even said that at one stage 'Can somebody tell this hysterical woman, this is necessary' as I was roaring in pain. ... And I thought you just don't see me here as a human being. OK, maybe you are very, very busy, maybe you are very, very skilful, you are HIGHLY overworked, but you can do with a little bit more training, you know, don't turn me into a medical problem. If I have a medical problem, but I am not A medical problem, you know. ... They were talking above me but not to me. I just felt like that I was almost stricken like everything being raped. I really, REALLY felt violated in the end, you know (We).

We provided a vivid illustration of the depersonalised institutionalised care. She was resentful that her emotional needs in childbirth had been neglected by this medical professional and she was turned into a medical problem.

Chinese women tended to be less aware of the medical hierarchy than Scottish women but they are also affected by the approach the health worker communicated with them.

... she [a midwife] really annoyed me, especially when she pressed the emergency alarm that made me really nervous. So a feeling of distrust, grew quickly and I began to have no confidence in her and to let her take my child away (W4) (§8.3).

In addition to the communication problem there were a few cultural clashes in social expectations here. This Chinese woman expected her midwife to be well prepared for this emergency situation and to be ready to tackle this foreseen problem without summoning help. But the midwife who attended her birth was expecting her superiors and medical staff to be present in case something went wrong. The Chinese woman was not able to see the whole structured organisation of labour management within which a midwife practises. This distant and invisible authority of professional power of problem solving was completely out of the experience of this Chinese woman. The

power and autonomy of this practising midwife was felt fenced around by constraints imposed by the dominant obstetric profession.

The failure to interact with the different social expectations of the woman can also be seen in the following:

... she only mentioned that my baby might be a little bit more sleepy. I thought at that time since you know what was going to happen, why didn't you get everything prepared beforehand and give the baby an injection right away to reverse it after its birth. So when I heard the emergency bell, I could hardly control myself and burst into tears. When the baby came back to me and then sent to postnatal ward, I did not trust those midwives any more and requested to let my husband take her there. I asked my husband to go together with them because I was afraid that I might lose my baby again (W4).

The quote above conveys me a few things. First, like most mothers this woman had no knowledge of how the labour ward was run. Second, the midwife had not explained the routine working procedure to the mother and had not prepared her well for the emergency situation, though she was aware the pre-term baby might have some problems once it was born. If she had explained that the neonatal resuscitation room was at a different location and the baby might need to be seen by a paediatrician there, this episode of fear and distrust could have been avoided.

By contrast another Scottish woman with an emergency caesarean section had a more positive experience towards the way the doctors approached her.

I think they were very good at (short pauses) explaining what happened. In fact ... they would ask you 'Do you mind if we do this' and 'Would you like that'. Even to the extent when the consultant decided to give me a section he said 'Do you mind if we section on you?'. He was very apologetic about the fact he had to section me, which, I think, is a nice approach anyway. I thought the communication was good (Wa).

This more considerate treatment may be because the woman was a health worker herself.

One instance of professional contesting between a doctor and a midwife was experienced by and upset a Scottish mother who had a Kielland's forceps delivery.

Eh (short pauses) she [the doctor] disagreed with Eileen [the midwife]. She had driven the midwife insane. The midwife thought I was further dilated but the doctor didn't. I think the midwife would prefer to manage me on her own. Because he [the baby] got very distressed, so the doctors had been involved, so she [the doctor] actually delivered the baby (Wb)

The midwife mentioned above was overtly taking more decision making responsibility but clinically her position in decision making was subordinate to the doctor though she may have had more experience. The professionals' view of hierarchy of status and the

hierarchy of skills further complicated their relationship. The midwife demonstrated her desire for more autonomy and was defensive of her position when the doctor did not respect her judgement. Their different clinical judgements left the woman in a puzzle about their respective professional competence.

The majority of women expressed their appreciation and gratitude to doctors and midwives for the care they received and the nice experience they had during their childbirth and their stay in hospital. Nevertheless seven of the ten Chinese women could not remember who was a doctor and who was a midwife even though on many occasions the midwives and doctors introduced themselves. They just assumed that they had a doctor to look after them in hospital in China they could and should have one here too when they have their child because the standard was higher here. They focused on the process of their labour and possible outcome of it rather than the observation and experience of the subtle power relationship between the doctors and midwives. They felt embarrassed or did not bother or did not have the language to ask about those professionals' status. They felt if it was generally good for Scottish women it was good enough for them and that they could not ask for more of this free medical service (W2).

Though midwives are trained to deal with people, sometimes this training does not take account of the cross cultural communication. This problem was highlighted by one Chinese woman, who had a straight forward vaginal delivery at 36 week gestation.

[In the labour ward] I felt very tired at first, I felt so sleepy after that injection [diamorphine 10 mg], she wanted to talk to me all the time. ... What she [the midwife] talked about was herself, her husband, and her cat. That was nothing wrong to talk about those things but I was in constant contraction pain. I felt pity on her because she had no idea how I felt (W4).

This midwife used a professionally recognised distraction technique from the standpoint of her own micro culture. On a superficial level the quote above reflects a general failure of the midwife to read this woman's mind. On a deeper level she could not find a topic that they both shared. What she talked about did not interest the Chinese woman very much as (1) she was in pain; (2) most of the Chinese do not keep pets; (3) husband usually was the last thing for a Chinese woman to talk about, especially to a stranger. In general the relationship between a couple appears distant in public but very close in a domestic sphere. To talk about one's husband to a stranger would often deserve disapproval because of the possible association with intimacy. The phrase 'That was nothing wrong to talk about those things...' reveals that she acknowledged what was normal for Scottish people even if she herself did not adopt

this behaviour. Distraction technique is an accepted method for midwives to help women to deal with pain. The problem here is how to distract individuals of different cultures and values from their own.

Fear, panic and frustration affected the women's ability to co-operate with the delivery team. Often much of this may also apply to Scottish women. A midwife manager said

...it [looking after a woman during labour] is a very convoluted process. It has everything to do with psychology, condition, pain, and cultural background' (Pa).

The above is only the illustration of some individual's experience of the relationship between themselves and the doctor or the midwife. Labouring women are vulnerable in the situation of uncertainty. Information can alleviate their fear which distresses them and inhibits the physiological process of labour. The experience of childbirth of an individual can be affected by the different perceptions of the woman and the different approaches of individual professionals.

8.4 Meanings of birthing practices

The 'meanings of birthing practices' for the women are dynamic and changing over time according to the changing social construction of the birthing practices themselves. It can be explored in terms of three different concepts: 'normal birth', 'natural birth' and 'hospital' birth. 'Normal birth' is the preferred term for the Chinese women meaning to fit into the current medical model and to accept what is the most common or 'safest' (§8.1.4). 'Natural birth' is a favoured term for Scottish women. It is ideological and conveys a sense of assertion, being in control and being free from medical intervention. The scope of 'natural childbirth' is too wide and difficult to locate and it is too ideological to be realistic for Chinese women. The meaning of natural birth varies in different cultures and for different individuals. In practice both 'normal' and 'natural' births are achieved mainly through hospital births.

The concepts of 'normal' or 'natural' childbirth can be directly related to the controversial issue of what is 'nature' and what is 'culture' in human activities. The whole issue is beyond the topic of this thesis. The reason to go through these problematic concepts of 'normal', 'natural', 'hospital' or 'institutional' is to have more insight into the different attitudes by different women from different cultures towards the socially mediated meanings of different birthing practices that are shared within the same social setting. It may aid understanding how Chinese and Scottish women in

Scotland construct a meaningful world or a social reality of their own in the face of the uncertainty of childbirth.

The concept of 'normal' childbirth did not make much sense for one Scottish woman.

It [normal childbirth] doesn't actually have any particular meaning I suppose. I don't know what 'normal' means. My experience of childbirth was horrific. At the very end ... it was stunningly sore. ... That was normal (Wc).

It did not give her any sense of romanticised image at all but a picture full of unbearable suffering.

Within a 'normal' range what matters to a Chinese woman is a female birth companion.

If everything is normal, I don't mind who delivers my baby, I think my body will be able to deliver the baby itself. Emotionally I really want to have female relatives beside me (W4)

As hospital delivery is the main reality in Scotland, people nowadays tend to see childbirth as a hospital event. The change of birthing site from the private sphere of the home to the public sphere of hospital has altered the social meaning of birth. It leads them to see childbirth as a medical concern and as well as a part of the welfare state's responsibility (§5.2). Eight of ten Chinese women in the study still maintained their view of childbirth as a private event despite the fact that they were expected to have their babies in hospitals in Scotland.

The Chinese women had little knowledge about British hospital routine and services available because of language and culture barriers. Only two of them knew about the routine and services. One of them had some personal working experience related to women's health and social welfare and the another got her knowledge through her partner working in a hospital. The Scottish women also found the hospital routines unfamiliar, they generally had better foreknowledge than the Chinese as they were born and brought up in Scottish culture. However childbirth had brought the women in both groups into an unfamiliar institution and bureaucracy.

A Chinese woman presumed she would know what to do when the time came.

When I felt pressure down below, I knew that I had to push hard. You could not push hard when the contraction was away. Very often I followed my body rather than the midwife's instruction. Her instruction was too fast than my body rhythm because of her insufficient clinical experience (W9).

Not all Chinese women were able to think through the body and follow their bodies to do what is right for themselves (§8.1.4). One Chinese woman revealed

I think perhaps they [the midwives] had idea when the baby could come out, but I had no idea at all, if I was left alone. I did try several times to push the baby out myself but they stopped me and advised me that was too early and too fast. They knew what they were doing but I did not (W7)

W7 provided a nice contrast with W9 about the midwife's direction over pushing. She conveyed a sense of distrust of her bodily experience and took the professionals' advice. It is also worth noting that Scottish women may also have this similar experiences.

Childbirth was unanimously seen as a natural process of human reproduction by all the Chinese and Scottish women in the study. But what is a natural process? Different people have different interpretations. Living in a new society with many obstetric technologies available, some of the Chinese women came to expect a certain amount of technology and welcomed pharmacological pain relief in their childbirth.

I feel I contradict myself. I like to have a natural childbirth but I would like to have something to make my labour painless (laughter). I think if I have not had this option, I may have done so. But since I have this option, why not use this option? So I think I am going to make use of everything (W5).

The perception of natural childbirth among the Chinese women is changing with the spread of medical obstetric practices, which reflect the changing pattern in maternity care.

'Normal' or 'natural' childbirth were the women's ideal, though their perception of this varied. The meanings of birthing practices were different between and within these two sets of women. Different conceptions and interpretations came from the context of a different individual. Childbirth is not a variable that may be treated solely as a biological event, nor a variable that can be explained only by reference to an individual psychological state and/ or shared cultural context and heritage. The behaviour and reaction to it vary according to the experience learnt from a different culture, which provides the individual with the meanings. These changing meanings are the critical variables that determine the experience of people. The social context and cultural background may affect how they feel, how they modify their behaviour during labour and how they interpret this natural process, even though they may not be consciously aware these influencing factors.

8.5 Summary

In this chapter, three issues are discussed — similarities and differences in women's choices and sense of control, their relationship with doctors, midwives and obstetric technology, and the social construction of the meaning of birthing practice.

Contrary to recent studies the hospital was viewed as the most desirable place for all the mothers in this study because of its predictability, controllability and its efficiency. This was based on the mothers' fear of the unpredictability of the childbirth. The partner was the first choice for all Scottish women' supportive birth companion but half the Chinese women ideally preferred their mother or mother-in-law though all of them had their partner present at their birth. All mothers found themselves having not much choice in their birthing position. They all delivered their babies in the maternity bed. A birth plan merely provided some basic information for the women in the study to think about and know what to expect in their labour. It required women's constant updating and readjusting.

The main difference in food between these two groups of women during labour was whether to fast or eat. The Scottish women were more aware of and advised not to eat or drink too much in case some unpredictable emergency situation might occur. The Chinese mothers would generally prepare themselves a light filling diet to prevent hunger and exhaustion in labour. Though both choices are prophylactic, their emphases are different; one is more medically oriented and the other is more geared towards a normal event. The women's attitude toward food was obviously culture linked.

Most of the mothers expected a certain amount of technology during their hospital delivery. Monitoring and obstetric technology of accelerating labour were commonly used. They were regarded as both reassuring and threatening. Some were reassured by CTG fetal monitoring and many welcome pharmaceutical pain relief to help them keep self-control. Many found the presence of doctors and sophisticated technology reassuring and this offered them confidence and security. Differences presented themselves in the different degree of compliance in each group of women. Chinese mothers appeared to be more compliant with routine monitoring and interventions, believing them to be the best care possible. Monitoring technology also increased the rate of intervention or instrumental delivery which was welcome by the women in the sense that they and their babies will be safe but at the same time

threatened their sense of integrity and control and increased their anxiety and fear. On the whole they were not fully aware of the effects of cascaded intervention.

The study suggests that the perception and tolerance of pain are culturally grounded and that culture makes pain tolerable by integrating it into a meaningful system. Chinese mothers tended to be less vocal while the Scottish mothers tended to be more articulate and have more pharmaceutical, medical or surgical intervention, although there is not a positive link between articulation and the intervention rate. Anyway the consideration of this cultural variable may contribute some ideas for future pain management.

The relationship between women, doctor and midwives was decided by the women's expectations and by the personality and manner of the individual professional. The major distinguishing features of the Chinese women were their attitude towards authority at home and in public. They were surprised that the NHS was there as a service to them, while Scottish women felt that they had a right to it. The reliance on and trust of medical staff was more marked among the Chinese than Scottish women. Scottish women associated midwives' attendance with normality. Chinese women associated doctors' attendance with prestige and better service. Both groups of women tended to err on the side that health workers knew better.

Labouring mothers are vulnerable because of the unpredictable nature of childbirth. The relationship between doctors, midwives, mothers and their new-borns was the conflict of different expectations, and struggle of control on an unequal base. The level of control and choice is dependent on, how the wider social context sees it, how much power the health workers are willing to give up and the women's perceptions of how unpredictable childbirth is and how much the actual course of events is determined by the progress of their babies and the response of their bodies. On the whole the control of women's bodies was felt by the women to be illusory because childbirth to them was normal only retrospectively. They did not see themselves as having ultimate control over their birth.

The two basic concepts: 'normal' and 'natural' childbirth have been differentiated. These concepts are the changing tactics in women's continuous struggle to solve the contradiction with the world around them and to strive for their control over their childbirth and their body. The relationship between 'nature' and technology appears to be the matter of control or power rather than a matter of 'nature' and intervention. The same metaphysical ingredients and processes are believed to exist in the human body and the body of society. The functions of these natural or spiritual

practices and the relationship between the progress of obstetric science and women's needs in childbirth require further study and exploration.

Childbirth is both a social and a physical process. These two sets of forces interact. Within 'the social', one can identify both social relationships between mothers, midwives and doctors and family and community and socially mediated meanings generally shared within both social groups. Birthing practices are constructed on the social values women hold and the norms they follow in accordance with the meanings of having children and images of themselves. 'The social' is shaped by both the mother and her culture, and as well as the institutional context of medical and midwifery practice with its medical culture. The accounts of their experience are social and cultural products of the environment that the women are in. These issues are further explored in Chapter 10.

The awareness of cultural differences among health workers is important in the management of childbirth. The health educators should be aware of the women's ignorance of the effects of cascaded intervention. This will widen their vision and put them in a better position to provide a holistic approach to care. Ideally all information should be made available to the health workers and they should be able to use it when needed.

Perhaps the important conclusion emerging from this chapter is that all women may have their individual needs in term of expressing their needs and choices. The way to meet their needs is to provide them with a channel to express what is important to them and to endeavour to provide safe, sensitive and effective care for them. Similar issues can also be observed in the postnatal period.

Chapter 9

Postnatal period: Chinese and Scottish women compared

Some reference is made in Chapters 7 and 8 to the cultural impact on the experience of the participating women during their pregnancy and childbirth. Similar findings can be observed in the post parturition period. The practice of postnatal care in Scotland has its routine and its ritual to follow. After childbirth women are visited by a midwife for ten days and then seen by her GP for six week postnatal checks, which is regarded as a signal that full domestic and marital responsibilities should be resumed (Cox 1986b: 8). This system is designed to ensure women's full recovery after their childbirth.

Given the wealth of empirical material I have opted to be selective rather than exhaustive here because of space limit of my thesis. Ten major issues around the women's postnatal daily activities are chosen and further analysed in this chapter to illustrate the marked differences and explore the postnatal experience of Chinese and Scottish women. They are:

- (1) Postnatal care and Chinese *zuo yuezi* in Scotland,
- (2) Mobility and rest,
- (3) Bathing and washing,
- (4) Pollution,
- (5) Food and drink,
- (6) Infant feeding,
- (7) 'Doing the full month',
- (8) Baby blue and postnatal depression,
- (9) Sex of baby,
- (10) Naming of baby.

This allows us to explore the relatively neglected question of how far the different postnatal customs and practices help explain the changing meanings attached to changing postnatal practices.

9.1 Postnatal care and Chinese *zuo yuezi* in Scotland

The current maternity postnatal care in Scotland (§5.3.3) emphasises the new mothers' early mobility rather than rest, although the postnatal period is recognised as a period of immense physical and psychological adjustment in both Chinese and Scottish cultures. Bed rest is reduced to hours following vaginal delivery (Tew 1995: 183). In hospital the women are expected to be up the next day and take an active part in the care of their babies (Tew 1995: 218) because they are told there are many known benefits for them to be mobile as soon as possible after birth, for instance, to facilitate their physical recovery, to prevent deep venous thrombosis and to help bonding development etc. (Enkin et al 1995: 345). All the Scottish women in the study were happy to follow the medical and midwifery advice to various degrees, but some Chinese women found some difficulties.

The main reason for the Chinese women to stay in hospital was to rest and to recover (W9) but they could not do so simply because of

... the differences between the Chinese customs and that of the people here [Scottish people]. They do not need much bed rest. Very early in the morning everyday they came to make bed for you, so you had to get up for them (W9).

Once again Chinese women explained away their different approach to rest by suggesting that Scottish women have different needs.

The Scottish women usually accepted hospital routine and took an active part in their baby care as soon as they felt able to. They started to consider themselves back to normal when they went home. It was very common to hear them saying 'As soon as I'm home, I'll be back to my routine (Wg) / I'll be OK (Wj). Hence hospitalisation was possibly taken as a different routine because they felt that they had to function under the hospital rules in terms of when to get up, when to have their meals and when to have their postnatal check-ups. Hospital routines and baby's needs dominated their daily activities during their stay in the hospital. They felt being in their own home would give them a sense of being in control and they could do things at their own pace. The care of their baby would fit in with their daily routine.

In some cases Scottish women that the felt midwife's postnatal visits were too early everyday. One woman suggested afternoon visits.

I felt I had to be up and dressed for people coming. I was a bit under pressure to get myself and baby ready for them coming at half nine or ten o'clock. If it was in the afternoon, it would be much better (Wb).

The partners of eight Scottish women stayed off their work for about a week or two, and one of them, a month to help the woman with her routine housework and looking after the baby. Domestic help was apparently considered important by both groups of the women to ensure a good recovery after their childbirth. This is especially true among the Chinese women.

Nine of the ten Chinese women still believed in the importance of rest in the first month after delivery rather than mobilisation to help them regain their energy and strength. Some Chinese women considered early postnatal mobilisation was only appropriate for the Scottish women. They considered that this period of being cared for and being free from domestic duties was crucial for their immediate recovery, for prevention of chronic illness, and also for strengthening their intra-family ties especially between their mother and mother-in-law (§4.3). Though only one Chinese woman had her mother-in-law nearby, half of them managed to invite their mothers-in-law or natal mothers to Scotland to help them *zuo yuezi* (§4.3.1). Hence this integrated set of postnatal practices remained strong among the Chinese mothers even in the Scottish setting.

All Chinese mothers appreciated the merit of the midwife's ten day postnatal checks and felt lucky to be getting so much attention, but they still followed their traditional *zuo yuezi* to some degree. The traditional women would follow most of the practices in a way, if possible; the westernised ones would observe selectively some of the prescription and proscriptions in order to have the best of both postnatal practices. No Chinese woman actually turned her back on these customs and practices completely, because 'There were many things you just followed and never fully understood why' (W9).

The customs of *zuo yuezi* in Scotland consisted mainly of the following five practices in the first month postnatally:

- 1) house confinement or discouragement of mobility,
- 2) caution on physical contacts with anything associated with coldness, for instance, cold wind, cold water, ice, cold food, some fresh fruits and so on,
- 3) well balanced postnatal diet according to the principles of *yang* and *yin* or 'hot' and 'cold',
- 4) freedom from domestic duties for the month, if possible and

- 5) abstinence from excessive pleasure-seeking (i.e. coitus, reading and watching TV) or engaging in recreation activities.

The detailed postnatal activities are further analysed in §9.2—§9.7.

9.2 Mobility and rest

How long should a healthy woman rest, be away from her domestic duties or retiring from social activities after her childbirth? Now general acceptable practice in a Scottish maternity unit was a day or two. The mothers were expected to take the responsibility of looking after their baby soon after the birth and they were expected to get up and care for themselves. The length of time to rest and to mobilise appeared to be determined by fashion rather than systematic assessment of the needs of the mothers (Enkin et al 1995: 345).

All the Scottish women resumed their social and domestic duties soon after they returned home but three of them felt their activity level was excessive, rather than usual.

For two weeks after [childbirth] we didn't have one day on our own [She had visitors everyday]. So we are absolutely exhausted (Wb).

Wb felt that her active social life overloaded her with visitors and celebrations and impeded her physical recovery. The evidence from a study on postnatal women in England (Herbert 1994) also suggested a similar finding.

Regardless of the development of medicine and modern midwifery practices, the Chinese custom of *zuo yuezi* is generally accepted as the measure to guide and protect the women and followed by the Chinese mothers in Scotland. Though most of them felt well, they found it difficult not to observe the restriction on contacts with cold water, cold food, cold wind, just in case they might catch some kind of illness in their old age. A month house confinement was still in practice. This can be supported by a reflection of a Scottish professional:

...they [Chinese women] couldn't understand why you've got to get out of bed, you got to wash. They couldn't understand DVT [deep venous thrombosis], you got problems' (Pd).

DVT and the other down side of *zuo yuezi* did not appear to be a problem for the women in the study. Most of them were walking and moving about in the house

though they did avoid engaging in full-time housework for at least the first month post birth, if this was possible.

I have to stay in for a month, in case I catch wind (W1).

You can't go out in a month time. You are expected to rest for a month (W9).

Seven out of the ten Chinese women had to start housework earlier than they were expected because of the absence of assistance from the extended family and two of them complained of aches and pain in their joints of fingers and legs. They observed *zuo yuezi* in the sense of minimising the tasks they have to do. None of them were found to engage in sex or other recreation activities within the month though one of them expressed the desire to but her physical discomfort had prevented her.

Two Chinese women stayed at home during the month and refused to have any visitors. The postnatal interviews of this study had to be postponed until this month was over. This kind of experience is beyond the experience of a Scottish woman. Some Chinese women expressed their amazement at what Scottish mothers could do and were very interested to know what could possibly happen to Scottish women in their future. They tried to link this to the high incidence of rheumatoid arthritis among older Scottish women. The only one who did not follow the rules of *zuo yuezi* was the second time mother from Hong Kong. She felt this custom is unnecessarily restrictive. Both her mother and mother-in-law stayed nearby but she preferred to cope on her own. She would like to do what the local people did, in order to fit in the current cultural context as an immigrant.

In general the westernised Chinese women followed the present medical model. They went out to meet friends and to do shopping, and looked after themselves and their babies from the start. They soon discovered that they were too tired and needed some kind of domestic help. They felt domestic help was vital to rest.

I may really need some form of traditional *zuo yuezi*. I really missed my mother. My husband [a Scot] said that we two would be sufficient to tackle the problem. He worried about my mother's interference. He said that the child is ours. Later I discovered that husband could not help me, though he is a nice person. Husband was too busy. ... I felt I could not get used to this. That was why I felt so tired at that time (W5).

The different expectations and experiences between this Chinese woman and her Scottish husband are well illustrated in the quote above.

Reading, watching TV and sitting in front of a computer during postnatal period are not advisable as they were believed to have permanently damaging effect on

mother's eyesight. Some of the Chinese women in my sample believed in the 'permanently damaging effect on mother's eyesight'. They worried about this 'side effect' and sought assurance and reassurance repeatedly during their postnatal period. It is also important for Chinese women to avoid perspiration at this time since it is considered to be associated with fits and 'wind'.

One woman from Taiwan was surprised to find out that the customs and practices before and after childbirth were so different between the women in Taiwan and those in Scotland. Pregnant women in Taiwan usually work to the last moment before birth then they begin to 'sit in' for the month after the birth. But Scottish women stop working two or three months earlier to wait for the arrival of the baby, and resume all social activities soon after birth.

Postnatal restrictions were seen obligatory and followed closely during the postnatal period. Eight of the ten Chinese women believed that they may suffer incurable 'wind' syndrome (§4.3.2), if they do not follow this custom. If a journey had to be made during this period, the woman was well wrapped up.

I remember now in fact I went to hospital with my son once when he got fever that night. It was a rainy night I had to wear wellington boots, big coat, raincoat and my head was well wrapped with a scarf. I was so well tightly wrapped up that I could hardly move. Normally you don't have all those aches and pain right away, if you did not sit in for the month properly. They will occur when you are in your old age. There is a saying in our area that the illness you got during the month can only be cured in the month in your next childbirth.... This custom was passed on from one generation to another. If you said you didn't believe it, that would be fine but when it came down to your own health, you would believe in everything. You might say it wasn't much use but when you were in that situation, you would think that was good for you. ...(F6)

Three Chinese women in the study believed that the only cure for the illness contracted in the month is to sit in for a month in an absolutely correct way after the next childbirth. With the introduction of one child policy in China since 1980, many people in the mainland China have lost the opportunity to give birth to their second child. Therefore they lost an opportunity to correct the mistake they made out of 'ignorance' in the previous postnatal period. This mistake correcting therapy has developed further into '*zuo xiao yue*' (footnote in §4.3.1), but there is no evidence suggested by this study to indicate the presence of this practice in Scotland.

Like other social phenomena, there are the rules for ideal and the actual behaviours of women in the custom of *zuo yuezi*. On the one hand no woman actually followed all the prescribed or proscribed rules. On the other hand, rules of *zuo yuezi* were ideal rules of customs. There was a distance between reality and an ideal health

restoration behaviour in a similar way as the evidence of Jeffery et al (1989) in India. These practices were followed to various degrees after parturition according to each individual's needs, environment, family condition, financial state, and educational status. The extent that a woman observed the rule with regard to her health status was also an indicator of her social status within the household and the position of her household in the community. Anyway the data pointed to the greater concern shown to the mother during the month was enough to preclude her from experiencing postnatal depression (§9.7).

Chinese women have observed the host people's postnatal behaviour and experience of a hospitalised childbirth. Although *zuo yuezi* has been a custom generally recognised by them, many of them still felt an uneasiness and a cultural ambiguity living in Scottish culture. They too, noticed that many Scottish practices had in fact done no harm to health so far. They thus found reasons and excuses not always to follow the traditional *zuo yuezi*.

9.3 Bathing and washing

Baths and showers after giving birth were not recommended by Chinese tradition because they were thought 'cold' and could cause aches and pains in women's old age. All Chinese women in the study had a shower/bath or showers/baths at some stage in their first month postnatally. But washing the hair remained a taboo for four of them. All of them had demonstrated to various degrees their close tie with or knowledge of Chinese rural culture.

I was told to wait for a month [before washing my hair] by my family at home over the phone. It is our Chinese custom (W1).

Another woman had a similar experience.

I haven't washed my hair for more than a month now. I perspired a lot during the birth. My mother-in-law has insisted that I shouldn't wash my hair so did my neighbour's wife. ... Washing hair after childbirth was believed the major cause of headache. My mother-in-law said the hair could not be dry immediately and it was no good to use hair drier either. If a hair drier was used, the wetness would be blown right into the brain (W4).

As mentioned (§8.1.2), W4 was an academic specialising in rural Chinese women's decision making in the Southwest of China. She often presented herself in a traditional Chinese way at though she had been ready to accept western culture and had herself converted from a Buddhist to a Christian. But another Chinese woman from Taiwan had a different thought on the issue of washing hair.

I think in China when we were young there wasn't any hair drier. If you washed your hair in the month, the hair was wet and if there was any wind, it would be easy to catch cold. Your resistance to disease after childbirth is the weakest. The customs of no hair washing and no bath are designed to prevent you from suffering. If you really get ill in that period, it will create a lot of problems (W5).

Washing hair and bathing were not big issues for the Scottish mothers. They all had a wash or a shower 1—24 hours after childbirth for perineal or wound discomfort (Sleep 1991: 222-248).

I had a bed bath after the baby was born. I did myself. I had a shower the next thing because I couldn't sit in the bath (Wb).

Scottish postnatal practices offer the Chinese women some flexibility in the observance of their traditional customs of bathing and washing. One Chinese woman thought:

Washing and bathing seems to be fine for them [Scottish women]. I think it is probably OK to have a bath (F6).

Some women took advantage of this and modified the rules. Others adhered to the tradition by avoiding bathing, washing hair, and/ or touching cold water. The westernised Chinese women did what the Scottish women did and the less westernised modified their personal hygiene custom within their rationale.

I did not have a bath that day, though they kept on asking me to do so. The next day they persuaded me that a bath could facilitate wound healing so I decided to have one (W9).

You never know what will happen to you until you are old. You are afraid just in case something happens to you when you are old' (W9).

The distinct prohibition of washing, bathing and contact with cold wind and water were thought to be created for the protection of the long term well-being of the mothers. The prohibitions and dissuasion of these in a modern improved health environment and medical condition may not all be seen as necessary, but bathing, washing hair and outdoor activities after childbirth were still considered by Chinese women in the study to expose them to contagious diseases in some way.

Unboiled water conventionally, was thought not suitable even for washing purposes by the Chinese (Tsay 1918: 535). This knowledge might come directly from practice but it coincided with the aseptic concept in western medical care. All the Chinese women in the study complied with local customs and used warm tap water to bath/ wash/ sponge themselves down and their baby because

The tap water in Scotland is cleaner for washing purposes(W8).

W10, a westernised Chinese woman, repeatedly stated that she was brought up to bath everyday. She thought it was unimaginable to bath in a bath used by others in hospital because of cross infection. She had a shower everyday during her hospital stay after the childbirth. She was surprised that Scottish women did not mind sharing a bath used by others.

It is unimaginable for a Chinese to bathe in a bath used by others in hospital. The bath must be full of germs. It is very dangerous to a newly delivered mother, especially those with a wound. I am sure that no Chinese women will use a public bath. The first class maternity ward in Hong Kong has just a shower within each room. It seems the foreigners do not bother much about the cross infection (W10).

Though she had a shower or a bath everyday, she did not wash her hair at all in the first month postnatally.

Many Chinese women believed 'wind' syndrome (§4.3.2). Four Chinese women did not wash their hair and made no contact with cold water, draughts, while the rest washed their hair and hands with hot water at some stage in the first postnatal month. Two of them (W5, & W8) felt their needs of personal hygiene outweighed their beliefs and the disadvantage of this health restoration of no washing.

One Chinese woman (W1) from a rural area bathed herself in hospital by adding Vodka to the water in order to put this bathing act into a somatic balance. Although the bathing water was hot, bathing was still considered 'cold' therefore Vodka, a 'hot' agent, was added to reverse this cooling effect. Another bathed with boiled ginger water. One woman told her story of being not able to follow the custom.

In hospital I had to wash my hands with cold water. Because of this I had pain in the joints so I had to put more clothes on [to counterbalance the cold status of her body] (W9).

A herbal steam bath on day 30 post childbirth was reported informally by three Chinese woman friends and a professor of Chinese medicine from the south-west of China in Scotland but none of the Chinese women in the comparison group did this. All of them had a bath or baths at some stage during the month.

When the month was over, my husband got me quite a lot of Chinese herbal medicine. He boiled a big bucket of water together with the Chinese herbal medicine and took the boiling herbal water to a bathing pool. He asked me to stand beside the pool with a bathing cover to have a steam bath first and got into the water until it became hand warm. I was covering with sweat and felt as if all those poisonous stuff or waste products were dispersed with sweat. You felt as if you were in a steamer.... I washed my hair as well. People said in this way all *hanqi* (cold air) would be dispersed with the sweat and herbal water (Laughter) (F6).

This steam bath is a popular therapy in Chinese medicine. According to those informants many Chinese women used it if their birth happened to be in the cold seasons. If it was in hot seasons, they would possibly have to bath weekly or fortnightly because of sweat and smell. They would try to delay their bathing as long as possible until the month was over.

In summary bathing and washing hair soon after childbirth posed no problem to Scottish women as they were perceived to facilitate personal hygiene and wound healing, but detrimental to some Chinese women. Being in an environment that was different from their original one, six Chinese women felt socially compelled to comply with the local custom. They followed the local practice by minimum bathing and washing, by adjusting water temperature or by adding some hot agents to obtain a cosmological balance, such as alcohol, ginger or other herbs.

9.4 Pollution

Some studies indicate that the period of postpartum confinement is a time of pollution for the new mother, her child and the people who assist in her care (§4.3.3). However this concept of pollution was not reflected from the interviews with Scottish women. Some observances and taboos persisted among Chinese women in food, in daily behaviour and movements. Chinese women were perceived to be prone to the influence of evil forces and also dangerous to others. These observances and taboos were reinforced by the traditional medical theory of *yin* and *yang*, 'hot' and 'cold'. Any deviation from the rules would be seen to be a source of bad luck brought on by the uncertainty of childbearing to the community around.

All the answers to the questions to the notion of pollution or 'uncleanness' were 'no' throughout, for instance,

I did not have any strong feeling toward it. The only thing I felt strongly is to have a big bath. I worry too much, I haven't had a big bath since I was pregnant because I was prone to vaginal infection and worry about catching infection and influence baby. I take shower normally (W5).

W5's reaction to childbirth pollution was the need of her attendance to her daily personal hygiene. This is similar to the notion the western people have. People in the west would raise their eye brows, if the women did not wash themselves. Different people have different ways of understanding the notion of pollution. Hence the trace of pollution of childbirth is valid in a sense of body secretion, body fluids and cross infection.

Though Chinese women rejected the notion of birth pollution, the trace of this notion was still present unconsciously. The reinforced seclusion by their custom of *zuo yuezi* (§4.3.1) from other social and ritual activities was in fact, in a way to prevent the spread of birth pollution. Seclusion has lost its sense to Scottish women. No one nowadays bothers to ask why in the 18 century Scottish women were not allowed to go to church in the first six weeks postnatally .

The possible reasons for the negative response from the women in the study can be fourfold: first, the concept of pollution is disappearing; secondly, all women belong to a generation of cultural change; thirdly, they have completed at least compulsory education; and lastly, they rejected the notion of pollution.

9.5 Postnatal diet

There is a different emphasis for Chinese and Scottish women on diet during postnatal period. In both cases different practices were underpinned by different meanings. For a Scottish woman the focus of diet was on her as an individual to recover her body shape and on her inborn ability to supply what the baby needs, whereas for a Chinese woman the focus was on what was healthy for her directly and then what was healthy for her baby via her milk indirectly. Here the different emphasis of the meanings of being the mother could be further explored.

Postnatal diet appeared more important to Chinese women than antenatal diet (§4.3.2) because antenatal diet has not been considered by them to have too much effect on the health of the fetus and mother. The fetus is thought just to take what it needs from the mother regardless. A well balanced postnatal diet can ensure sufficient lactation, good milk supply for the new-born, and good maternal recovery from the birth and as well as preventing the woman from catching incurable conditions in her later life, which are thought to be the result of the imbalance of the diet intake during this period.

Dietary intake during the postnatal period was carefully calculated and balanced by the Chinese women. They customarily consumed an extreme 'hot' mixture of food for a month after giving birth to help them compensate for the blood lost in childbirth and recover (§3.2.2, §4.3.2). The most common 'hot' food for choice during this period were chicken, eggs, pork, gluten rice wine and ginger. Alcohol consumption was encouraged for those who could afford it. Dietary intake was carefully calculated and balanced. The belief in the medical effects of ginger and wine/spirit have been reconfirmed in the interviews with Chinese women in the study.

A soup was usually made of hot ingredients— chicken, wine, fish, dry longan (*guiyuan*) brown sugar and sesame oil. Sesame oil chicken was mentioned by three Taiwan Chinese women (W3, W5 & F2) and *guiyuan*, four women from Jiangsu and Guangxi (W6, W9, W10, and W11). The common food for consumption were chicken, pork, fish, spare-rib, rice, cabbages, bean curd and the like. Cold foods were generally avoided.

The mothers from southern China stated they usually had a special diet of chicken sliced into very small pieces, well cooked with ginger, vinegar and wine so as to make it extremely tender. In addition to chicken, pork was the most common and good food. And the women from the north or along the coast areas preferred eggs, pork and fish to chicken. Sometimes they (W6 & W 10) boiled fresh water fish because this fish was supposed to help lactation and wound healing if they had a perineal tear or a wound. Consuming the right type of food and eating at the right time were regarded as very important for the postnatal health of a woman. Soya sauce of any type should be avoided as it was believed to enrich the pigmentation of the scar. These beliefs and practices can be taken as some popular assumptions about the relationship between the human body and nature

Sometimes it was difficult for them to obtain their 'local' seasonal food. Some Chinese women tried port wine or barley wine instead of glutinous rice wine for strengthening the blood, fish with scales rather than scaleless ones. The scaleless sea fish was considered poisonous (§4.3.2).

Some Chinese think all scaleless sea fish are poisonous to some degree for women after childbirth. The country folks would buy those fish with scale or those fish they normally have (W1).

All their food had to be very soft and was generally well cooked. Presents from relatives and friends were commonly specially cooked food or the ingredients of special dishes for the mother.

The amount of hospital food provided during postnatal period was reported insufficient by both Chinese and Scottish mothers. A Scottish mother complained that hospital diet was not enough, especially high fibre diet.

... I don't think they provided enough fresh fruit. I don't think they provided enough roughage in the diet. I did end up with constipation. I have had very high roughage diet generally. I suffered a bit. People didn't bring me anything. I've nothing to eat (Wa).

All Chinese mothers shared similar views that the amount of hospital food was not enough for a lactating mother. One Chinese woman stated:

The food provided in hospital is simple and the amount is far from enough. ... one thing I am sure that the breast feeding mums should be able to have more soup. You need more soup to produce more milk. Soup and water are basic for lactation. The soup provided is not enough. ... They only provided you with plenty cold water and ice (W8).

However, none of the Chinese women mentioned any insufficient supply of high roughage food because.

Fresh fruits and high fibre diet are no good to a lactating mother. They are too cold (W10)'.

Fresh fruits and vegetables were regarded by them as too 'cold'. W10 had to put fresh fruit into a microwave to heat it for a couple of seconds before it was served in order to neutralise its cold status.

The beliefs of hot and cold food were taken seriously by the Chinese women in the same way as British women thought of food in their terms of calories and vitamins, for instance,

I have to pay more attention to avoid food of cold nature than those hot (W7).

No fried and deep fried food because of excessive *huoqi*¹ created in the body. ...Have you not heard of *huoqi*...? When your tongue coated with a thick white coating, that is caused by *huoqi*. I feel it is very difficult to explain the meaning of this to my husband [a Scot]. I think this may be the imbalance of the *yin* and *yang* Excessive *huoqi* means too much *yangqi* (W5)

Drinking ice water in hospital has initiated considerable anxiety in many Chinese mothers because it was thought too cold for a lactating mother. One Chinese woman said:

They drank cold water after birth. I found myself difficult to adopt to it. I had to drink cold water as everybody did. Apart from a big jug of ice water everyday, we were offered tea or coffee everyday. Nothing was suitable for me. The only choice I could make was tea. You have to drink that cold water or you felt very thirsty (W9).

But she felt as an immigrant that she had to drink cold water in order to fit in with the 'normal' practice of the new country

Another woman stated:

... the first thing they did after childbirth was to bring you a glass of ice water. If you caught any disease, you got ill right from the beginning. I

¹ The internal heat-- one of the six causes of disease in Chinese with symptoms as constipation, conjunctivitis, and inflammation of the nasal and oral cavities.

drank so much ice water during the postnatal period. The first thing my mother-in-law warned me on her arrival in Edinburgh was not to drink ice water (W4).

Five Chinese women had to face this challenging problem after birth whether they were going to drink ice water or tap water or not. They were too shy to ask for boiled water. As immigrants they felt that 'when in Rome, they had to do as Romans do'. All of them had to drink some ice water as it was thought the only drink available to them during their hospital stay. One Chinese woman adopted the western model of postnatal care and diet habits but still had some doubt and fear of the unknown future. It appears she was struggling to balance these two. This ambivalent feeling can be found from her testimony:

Since I started to drink ice water in hospital, I got used to ignore traditional restrictions. ... Many friends came to visit and advised me to put on socks and protect my feet. The leaflet I got [from hospital] did not mention these either. ... So I did not bother myself about this at all. If I did care, I should have been more careful about the icy water to start with (W4)

In a dynamic Scottish setting, dominant culture influences this Chinese woman's learnt health behaviours and beliefs. She started to learn western ways and at the same time she was reminded by the people from her own community to adhere to old practices and beliefs.

The examples of drinking ice water in hospital illustrated at least three issues: 1) Chinese women struggling to fit in even if it means doing something they believe is bad for them; 2) Chinese women not having a sense that it is fine to articulate their needs and wants; and 3) their acceptance of the authority of the hospital — as women used to deference and with a faith in the safety of the health care systems.

The choice of food during the postnatal period is a way of balancing *yin* and *yang*. This self-doctoring and self-medicating of dietary manipulation works well within people's understanding and beliefs and reinforces the folk tradition of the medicating function of food. The choice of food sometimes goes beyond the taste or satisfaction of physiological needs of the mother. It goes with the meaning and the significance of the food. Anyhow, the choice of food cannot be divorced from the subject of food availability and purchasing power of the family. Sometimes the local food supply and the family's financial state play a decisive role in their food choices, for instance, beef was not the first choice, but it did appear on the woman's table during the postnatal period simply because it is cheaply available. If this is the case the 'hot' and 'cold' state of the food will be carefully adjusted by the way of cooking and ingredients that are added.

Food is prepared for Chinese mother in a special way. It is normally boiled with fresh ginger root and with a touch of glutinous rice wine or rice wine as fluidity or soupy food is good for lactation. Chicken is thought to be a good hot food to help women recover from childbirth. The food needs to be hot but not so hot as to cause baby rash or discharge from the eyes.

The attitude toward the postnatal diet may appear 'dysfunctional' (Pillsbury 1978: 17) to some westerners but the active role of food in the cosmic, and psychological healing process cannot be denied. The advice the Chinese women in Scotland obtained through medical and midwifery professionals was applied in a non-contradictory way to their understanding of their own traditional practices and beliefs. When difference arose and no compromise was found temporarily within their individual knowledge, avoidance was the best policy. There were marked differences between western and traditional Chinese dietary advice but they appeared to be either integrated extraordinarily harmoniously or ignored completely. There are clear policy implications of diet as an area where greater cultural awareness would again be beneficial.

My observations and analysis of interpersonal interactions in Chinese households during the month lead me to another level of understanding the reason that far more attention given to the mother than to the new-born infant. This extra attention to the Chinese mother that the family and their social network displayed indicates the Chinese attitude to babies, their emphasis on and meaning of postnatal care. In Chinese culture babies are counted for what they can be in their future but not for what they are. They are not important when they are young. If they die prematurely, they are not allowed to be buried close to their ancestor's graveyard because their premature death is a sign of bad luck to the family. Multi-children strategy in family building is one way to ensure enough children to survive.

9.6 Infant feeding

Breast feeding was a dominant choice among both groups of women in Scotland because of changes both in the social attitude toward breast feeding as the result of midwives' concern and the growing evidence relating to breast-feeding (Renfrew et al 1990, RCM 1991, HEBS 1995, 1997). Nine of the ten Scottish mothers breastfed their baby and claimed to give their baby the best they had. Among them, six continued to the end of first month though three of them used occasionally formula milk to top up their baby's feed.

Three breast feeding Scottish mothers expressed their disbelief on the principle of feeding on demand. One mother said

That [feeding on demand] is the ideal, isn't it? But it doesn't seem to be working. ... He was absolutely starving. he was screaming for about five hours. It won't stop, he just wanted feeding, and my nipples were sore. I wanted to feed him but I was dry. He was sucking all the time. He was crying four hours during the night. ... I don't get enough sleep. Not having enough milk, he is sort of screaming. ... Nobody told me that I could supplement him with bottles. ... Why haven't I got enough milk? Yesterday I was fine, I got enough milk but the day before yesterday I needed a bottle (Wb).

The story Wb gave points to the midwife's concern on the effects on breast feeding of introducing formula at an early age. Mixed feeding in the early weeks was thought to undermine the success of breast feeding (Renfrew et al 1990: 25). The approach of absolutely no formula was felt insensitive by this woman because the needs of individual babies were different and the women's bodies could not be expected to function on demand as a machine regardless of their emotional, dietary and environmental changes.

Eight of the ten Chinese women breast fed their baby in the first month though one of them gave it up a month later. Another started bottle feeding after a two week breast feeding trial because

I really had no time to eat, and nothing good to eat. I haven't had enough milk. ... I felt this was really not so good. If he wanted anything, you just gave anything he wanted. This would be much better and natural (W5).

W5 worried about her insufficient diet because it was thought to affect the quality of her milk. Therefore she decided to bottle feed her baby in order to meet his demand. She felt more comfortable with bottles than with breasts.

Scottish women generally also thought that they had to pay more attention to their diet while breast feeding because inappropriate diet may upset their baby's bowels. But some of them were quite happy to give up high carbohydrate food and be on weight watching diet because 'there is no excuse to have an extra bar of chocolate now (Ma)'. They did not pay as much attention as they did during pregnancy to the well balanced diet. Their preoccupation at this stage was their own body shape and their own recovery. Many of them went back to their original diet before the pregnancy. Breast feeding did not alter their 'normal diet' regime. It seemed they had confidence that their lactation would be precisely tailored to meet their baby's demand regardless of their food intake. Their own hunger sensory perception would

effectively regulate the calorie intake for the breast feeding women (RCM 1991: 46) therefore the quality of their breast milk was not an issue for them to worry about.

When the baby was on breast feeding, Chinese women sometimes would choose to give their baby some boiled cold water, if the baby had a sticky eye, skin rashes or passed some brown or concentrated urine, because these symptoms were seen as signs of 'heat' or 'fire' (W8). Water (§3.2.1) is an antagonist, a cooling agent to these symptoms. Scottish mothers held the belief that the baby did not require water, because they were told by the midwifery professionals that breast milk contained exactly what the baby needed. Though the Chinese mothers had the same information they would adjust it flexibly according to their baby's condition and their customs. It seemed that the Scottish women were more faithful in adhering to medical and midwifery advice than the Chinese women. This implies that there is less of recent tradition of breastfeeding among Scottish women, so they have to listen to professionals. Whereas the culture of breastfeeding is stronger among Chinese women.

One Chinese woman preferred bottle milk to breast feeding because of her previous experience of artificial feeding with her first child. She thought

It is unimaginable to breast feed a baby. You couldn't go anywhere freely. It is too much trouble (W7).

In comparison Chinese women in Scotland accepted formula milk baby feeding more readily because it was regarded as the product of industrialisation (F1), something different from breast feeding, readily available method (W4, W7) and a more civilised form of infant feeding (F1). For these reasons more and more formula milk consumption was seen among the educated Chinese mothers, who could afford. This formed a contrast to the group of Scottish mothers who were striving to return to breast feeding.

9.7 'Doing the full month'

At the end of *zuo yuezi*, there is an occasion called 'doing the full month' (*zuo manyue*). This is a celebration given to the new-born when he or she is a month old and safe and sound. It can also be seen as a marker of an end to the restrictions imposed on the mother, as the husband of a Chinese woman in the study suggested.

In our village we invite relatives and friends to do the full month after birth for the mother, but not for the baby. Normally the relatives who come to the celebration are those from the woman's family. No relatives from husband's family will come (H1).

The custom under discussion is that of the border areas between China and Vietnam.

However *zuo manyue* was suggested too early for the baby to have its celebration.

If you celebrate too early, the baby may die young sometimes. I have this kind of feudal idea, though I did not think much about this. I think I would like to celebrate his birth at about 4-5 months. Normally cot death takes place between 2-4 months. I think we are going to celebrate his birth after four months. ... I will arrange at any time that is convenient to me (W5).

A hundred days old party for a new-born child plays the same social function as the month celebration, which may include a ritual and a special get-together meal. The family may burn some incense and invite a fortune teller or religious practitioner to predict his/her future and give him/her a lucky name.

It is quite popular to have a party for a new-born when it's 100 days' old in our areas [Sichuan Province]. ... A month was not a suitable time for us because we had to move house on June 2. The new flat hasn't been fully decorated yet. So we decided to have a 100 day party (W4).

This celebration of 100 days marks a free access to the mother and the child for everyone. The baby can then be visited by family friends; before that the child is not supposed to be exposed to sudden noise or a new experience.

The Chinese women in the study adapted themselves to their social environment. They celebrated the birth of their baby in a more flexible way as W5 and W4 stated above. They would invite their friends to have a meal together at any time when it was convenient to them after the childbirth. They would receive some cards and good wishes and presents from their friends and relatives. The form of their celebration was getting closer to the local Scottish custom, or sometimes mixing the two.

By contrast, Scottish women (§9.2) would often celebrate the birth of their baby soon afterwards. One Scottish family arranged a party at home four days after a Kielland's forceps delivery. They received some cards and presents from their friends and relatives. This included slipping a silver coin into her baby's cot to bring him good luck. Again this reflects the greater emphasis on the baby than the mother.

9.8 Baby blues and postnatal depression

There are three types of psychological changes associated with the puerperium i.e. baby blues, postnatal depression and puerperal psychosis. Baby blues is characterised by the woman's mood changes and behaviour in the first 3 or 4 days

after childbirth. Postnatal depression is different from postnatal blues by severity and duration. It lasts longer and may or may not require clinical treatment and is associated with bio-social causes, for instance, moving house, marital tension etc. Puerperal psychosis is a severe manic psychiatric condition that requires prompt medical treatment. It is the most severe form. This section only focuses on the experience of baby blues and postnatal depression because no one in the study had experienced any symptoms of puerperal psychosis.

One Chinese woman in the study suggested that baby blues and postnatal depression were closely associated with the Western culture and they were unknown to many of the women in China. Another Chinese woman (W4) expressed her anxiety repeatedly in her follow up postnatal interviews because she did not experience the expected emotional changes during her postpartum period. She was agitated by the fact that everybody was talking about baby blues, and postnatal depression and she was wondering why she did not feel the same. So she decided that she was abnormal. Her sense of being abnormal, though it is an extreme case, illustrates how she constructed her understanding of body and health, and her sense of making and trying to fit in this new culture and practices.

Baby blues was the most common phenomenon among most of the Scottish women and seemed to be a reaction to their culture, and lack of social support. Their experience was in one way or another similar to the woman below:

I did a wee bit [have baby blues]. Some days I felt she [her baby] wanted me, my husband wanted me and nobody gave me anything in return. That wasn't the case. That was what I felt like at the time. I had bouts of crying but I mean, you just, + only you need is just a hug really. ...[It was] just for a couple of hours, you know, at any one time. I didn't get very often. That was it (Wd).

All Scottish women denied that they had suffered any postnatal depression but merely a short period of unstable emotional state.

When I got home, I did cry a bit as well, but not excessively. I think it's just hormones. I think, it was just a, I don't know, the release of having everything over. I suppose responsibility having the baby to look after. It's just a very emotional time (Wb).

There was only one Chinese woman in the study who showed some signs of postnatal depression. Her major complaints were her Scottish husband's rejection at her mother's arrival to assist her to sit in for a month and the great pressure of breastfeeding and looking after her baby. She made her physical complaints overtly

and her psychological problems covertly. Her bodily complaints metaphorically reflected her personal and interpersonal distress at the beginning of her motherhood.

I feel my feeling at that time was caused not only by the birth but the problems of lack of sleep and lack of time to eat. I was anxious and felt pressurised. Every time when he cried, I wanted to hold him in my arms and hoped he stopped crying. Much of my energy had spent on being nervous. I think the feeling I had at that time was mainly a physical problem. I think if I did not have those physical problems, I might not have had those down feelings. ... Because I have no experience, I always hope someone can console and reassure me like my mother would do.... I have no one who can reassure and console me (W5).

Lack of domestic help from close kin was suggested by her as a major problem by articulating her strong wishes of having some one to help her.

Chinese society has prescribed its rules to support and monitor a mother's behaviour in sitting in for the month. Postnatal cosmic well balanced diet, rest and postnatal taboos are the observations and restrictions that a mother has to observe. Extra care is given to the woman by her mother, mother-in-law or her wider social network and she is accompanied by her relatives during this month. She has three roles to play: to negotiate her new relationship with her own mother or mother-in-law, her husband, and, in addition, she has to mother her baby and develop a new bonding relationship with him/ her. In return she becomes the centre of the family for at least a month. These traditional practices appear to have a great bearing on the psychological well being during a woman's recovery from childbirth. Any breaches of these practices may result in an imbalance in the woman's psychological well being.

9.9 Sex of baby

Seven of the ten Chinese and five Scottish participating women happened to have a girl, the rest had a boy or twin boys. There was not much difference in their overt feeling in having a girl or a boy but the feeling toward the sex of baby (§7.2) was different in their partners and their parents generation.

He (Wd's husband, a Chinese man) would like to have had a boy because we've already had a wee girl. I think he is disappointed but I love her anyway, because for a woman the moment you know you are pregnant, you love that baby, you know; but for a man it is different. He would not really form a attachment at all until it was born (Wd).

The reaction to the birth of a child tends to be determined by parental definitions and expectations. If they expected to have a son to pass on the family name and link up the generations, they were disappointed if their anticipation was wrong. This was also true for Scottish women when it came to the questions of perpetuating

the family name (§7.2.1). Male child preference remained unchanged among the older Scottish generation but things were getting to change slowly with the younger generation:

My father said it would be nicer to have a little boy. That is my dad, a bit of old school type. My husband, no, he is delighted with her, I think. Nowadays in our society, women can do anything men do basically. When you look at a sort of education prospect, I think, we don't think we can deter her from what she wants (Wa).

One of the Scottish women stated that she felt she was treated differently after she had a son: '... I am sure I was more patted (Wc)'. The different attitude towards the male child among the Scottish generations was also felt by a Chinese woman.

My father-in-law [a Scot] may regard boys as superior to girls. Anyway he is quite elderly. ... I haven't had much different feeling yet. Perhaps because I've already had a son (W5).

When it came to the discussion about the difference between having a boy or a girl, the Chinese woman who already had a boy appeared to talk in a more confident and relaxed way (Cf. W5's quote above).

It doesn't matter whether to have a boy or a girl. In fact a girl is often more considerate and more sympathetic to her mother (W6).

Her voice and tone revealed the security and confidence in herself and her position within the family and at the same time expressed her wishes of completeness if she could have a girl too.

Male child preference prevailed in the Chinese community (§ 4.1.2). The social acceptable form of this son preference is presented in a form of hoping and guessing a boy pregnancy to please the mother (§7.2.1). When the reality became the opposite to her expectation, it often disappointed her after the childbirth

At the very beginning I said I did not mind if it was a girl or a boy. But when I was told it was a girl I felt so disappointed and surprised, because everybody kept on telling me that I was going to have a boy. All Chinese said so (W4).

She was convinced that people around her tried to tell her that she was having a boy simply because they thought she liked to hear this.

... their family wanted to have a son, they kept on saying that I was going to have a boy, which included my partner's mother. She said I was going to have a boy from the abdominal shape and line of my photo during my pregnancy. They did not believe how I could manage to give a birth to a girl (W4).

It turned out that she had a difficult time with her partner and her mother-in-law after the birth of her baby girl, although both her partner and his mother kept on saying to their acquaintances that there was no difference between having a boy or a girl (§4.1.2).

My partner's mother also said the next one would be a younger brother. So I feel it is not the way they treated me but the way they reacted to my baby girl. ... Though I hoped to have a boy, now I love her so much that I would not change her for anything (W4).

The husband of a Chinese woman stated

My wife phoned me and told me 'It is just a girl'. I said to her a boy or a girl were just the same. ... The most important thing is the child's behaviour and its obedience.)(If it is a boy and he does not behave, you'll end up with endless trouble. ... I haven't got much education but I deeply believe not to go against the will of Heaven, otherwise you'll lose your inner [psychological] balance (H1).

The message he was trying to convey was that his wife's preference for a male child was much stronger than his and he felt that people had to take what they got and try to be content with it.

The expression of male preference is thought socially unacceptable. One of the acceptable techniques used by both groups of respondents is to say something unacceptable through the third person. This may account partially for the conclusion that partners' and their parents' male preference stronger than the respondents'.

9.10 Naming the baby

The name is a live myth to be bestowed upon the child. On the surface level it is a label for identification. On a deep level it is not. The choice of a name is often a result of the conscious and unconscious parents' deliberation of their personal meanings and expectations.

All Chinese women gave their baby an English and a Chinese name. The English name was thought easier for local people to use and the Chinese name, a way to preserve Chinese identity. One Chinese couple (W8) spent their first days 'playing' with the sound of different possible names they thought about before the childbirth. They also picked a Chinese name that was thought to bring out their child's features, personality and equivalent meanings in Chinese.

Another Chinese female baby was named with a pun that has the meaning of bringing a younger brother to the family in Chinese and a cat in English that can

overpower and destroy a rat in Chinese cultural context as the baby was born in the year of rat; which was believed to be the best year to have a male child. There was a Chinese couple named their baby after a Chinese Buddha's saint in the hope that the baby would be empowered with his attributes and embodied part of his soul, even though they had themselves converted to Christian after the birth of the baby.

Two Scottish couples chose their baby's name from a baby name dictionary on the basis of its entry's definition, story, fashion and history. Six picked the name that sounded good to them in terms of association with a film star, football star or other significant person's name in the family or community or society in a wider context. One Scottish woman from a mixed marriage selected a name that had some association with her husband's culture and mixed with the message of the parental expectation of the child and the personal meanings of the name chosen.

9.11 Summary

In comparison it appeared that Chinese mothers presented more varieties within themselves in their beliefs and customs and Scottish mothers were more unanimous in beliefs and customs, and followed prevalent western medical and social models. Early mobility was well accepted by Scottish mothers but not so well by some Chinese women because of their custom of *zuo yuezi*. *Zuo yuezi* seemed to remain an integrated postnatal behaviour for the Chinese women in Scotland. It served as a social sanction for them to rest, to recover and to prevent future illness, a consolation and a prompt for them to concentrate on their baby and their role of breast feeding, as well as an occasion to strengthen the intra family tie between the woman and her own mother or mother-in-law.

The evidence in the study indicates some differences between the groups. The postnatal diet was more important to Chinese women in the study than that of the antenatal diet according to their customs. The opposite was true for the Scottish women. In both cases different practices were underpinned by different meanings. The focus of diet for Scottish women was on her as a mechanical feeding function and what was healthy for the baby, where the focus for the Chinese women was on what was healthy for themselves. Chinese women believed a well cosmological balanced diet was able to ensure sufficient lactation, good maternal recovery and prevent future incurable disorders. They would do their best to apply those traditional principles of the postnatal diet pragmatically and enjoy their symbolic implications and as well as their nutritious values. Such a non-dogmatic social attitude may not be easily accepted by Scottish health workers. The example of avoiding ice water illustrated well Chinese

women's struggle to fit in even if it meant doing something they believed was bad for them. It also showed their acceptance of the authority of the hospital and they did not have a sense that was fine to articulate their needs and wants. However the practices of Chinese eating can indicate the concepts surrounding food as active agents in the cosmic, bio-physical and psychological healing process. The basic understanding of these empirical and cumulative therapeutic eating practices can facilitate the health workers to care for the well being of this group of women because this 'hot' and 'cold' principle may also prevent them from taking a well balanced diet in term of fresh vegetables and fruits.

Breast feeding was dominant among both Scottish and Chinese women. They demonstrate different emphasis on the babies and the mothers. Scottish women had more confidence in their body that would regulate their food intake and the milk supply but at the same time more of them were ready to accept formula feed compared with their counter part. This may because of a less tradition of breastfeeding among Scottish women whereas the culture of breastfeeding may be stronger among Chinese women.

The practice of 'doing the full month' reported in China was not closely observed by the Chinese women settled in Scotland. Nothing was found concerning 'sitting in for the small month'. No services like *zuo yuezi* centre were found in Scotland either, though some Chinese women felt they might need it because of their fatigue and postnatal depression caused by the absence of assistance by extended family.

The evidence from this study indicates that Chinese postnatal behaviour is embedded in its culture. The practices of *zuo yuezi* have a direct bearing upon the psychological well-being of the women postnatally and in their future life. Any negligence in observation of these practices will usually bring the women fear of those incurable aches and pains. This may suggest that they deserve the cognitive recognition of health professionals, who should be aware and respect their beliefs and practices which link the events of childbearing, the health status of women, and family relationships in order to provide better maternity care for this group of women.

Postnatal depression was a new concept for some of the Chinese women. *Zuo yuezi* places them in the centre of the family for a month, and serves as a prophylactic measure for them to reduce the rate of having these puerperal mood changes. Few of the Chinese women in the study managed to follow *zuo yuezi* in its

proper form. The failure of following the ritual of this practices may jeopardise the psychological balance of the women.

The overt expression of the preference for a male baby is considered socially unacceptable. The preference for a male child was presented in a form of hoping and guessing a boy pregnancy in the Chinese community. Male preference was usually voiced through another person. This leads to an interpretation of a stronger male preference among their partner's and the baby's grandparents. However, this preference was thought to be changing among the younger generation in response to social changes because women could do anything men do.

Every individual is different in terms of their educational background, socio-economic status, cultural and religious values and practices. To provide individual care in maternity service, it is important to understand some socio-cultural facts why something is wanted and how it can be met. The concluding chapter takes the analysis a step further by looking into the related questions, pulling together the analytical arguments of previous chapters and provides a reflection tentatively on future prospects.

Chapter 10

Conclusion

10.1 Introduction

My main conclusions are that:

(a) Childbearing is socially shaped and culturally specific for both Scottish and Chinese women having babies in Scotland. Their cultural background gives them a set of explicit and implicit meanings associated with the event of childbearing. My study builds on and highlights the theme of social and cultural construction of childbearing addressed by many authors, e.g. Jordan (1978), Leininger (1978), Giger and Davidhizar (1995), Yearley (1997: 23), Homans (1982, 1985), Schott and Henley (1996) (§1.2.4, §4.2, §5.2.1, §5.3, Ch 7-9). It has filled an empirical gap in the literature by providing new material on childbearing cultures of Chinese and Scottish women in Scotland. Especially Chinese women seem not to have been studied before and their needs may not be appreciated in Britain. The study also challenges the stereotyped models of transcultural behaviour to which nursing and midwifery practice are oriented (Leininger 1978, Giger & Davidhizar 1995) which are further discussed in §10.2 and §10.5. The study informs practice both in general and specific terms. The awareness of the complexity and dynamism of social and cultural construction of childbearing would add some new dimensions for health workers to relate to women, especially the Chinese, so that they can facilitate a better experience with the women they attend.

(b) The hospitalisation of childbearing forms part of the social organisation of childbearing in Scotland. 'Control' and 'choice' (§1.2.2, §5.3.2, §8.2, §8.3, §8.4) are complex issues in the hospitalisation of childbearing. These issues regulate the social relationships between women, women's bodies, their babies, health workers, obstetric technology and the wider social context (Figure 5 in §10.3.2). Although Chinese and Scottish women under investigation were in Scotland, the same social setting and their different cultural backgrounds gave them different expectations, choices and experiences contrasted with other ethnic minorities in the UK (Schott & Henley 1996, Homans 1982, 1985, Woollett & Dosanjh-Matwala 1990). These differences in women's experiences of childbearing are further examples of the social and cultural construction of childbearing.

(c) Chinese women, as other migrants and ethnic minorities, use the NHS maternity service when childbearing in Scotland, but at the same time, they adhere to and transform their original childbearing culture where they have found it meaningful in the new social setting. The inadequate literature about and insufficient understanding of this group of people and their health needs in childbearing further support the argument of Ahmad (1992) and Nazroo (1997a & 1997b: 258) that ethnic minorities in the NHS are poorly served in terms of meeting their linguistic and psycho-social needs (§6.5). Research on Chinese women's experience is vital to improve the understanding of their health and experience.

The details of the findings are presented in four sections: cultural meanings of childbearing, social choice and control in the medical institutions of childbearing, Chinese women as an ethnic minority in the NHS in Scotland, and implications for practice and suggestions for further study.

10.2 Cultural meanings of childbearing

The cultural meanings of childbearing can be observed in five aspects: 1) cultural meanings of having children; 2) social organisation of family surrounding childbearing and 3) childbearing as a social transition 4) different meanings and strategies in health in childbearing between Chinese and Scottish women, and 5) Chinese women selectively follow Chinese and Western medical practices.

10.2.1 Cultural meanings of having children

Childbearing is undoubtedly one of the most important social life events in Scottish and Chinese societies. Both societies have elaborate religious or customary ritual celebrations for the birth of a child. Having a child, for both societies, means the expansion of a family. Childbearing has been seen as women's business in both societies. A significant issue for Scottish and Chinese women in childbirth is their transition to motherhood (Homans 1982, Yearley 1997) which is further discussed in §10.2.3. The majority of Scottish and Chinese women in the study expressed their feeling of satisfaction, maturity and completeness in life in giving birth to a child and their emotional tie to the child.

Compared to Chinese women, becoming a mother is much more significant for the Scottish women than providing a compulsory heir to a lineage. Having children indicates the normal consummation of a heterosexual love relationship; in other words, the focus is on the couple's current relationship rather than support in old age or perpetuating the extended family. In general the Scottish women in the study did not

necessarily see childbearing as the fulfilment of a marriage but nevertheless it was significant for the marriage. This ideology is reflected in the Scottish expectation of the partner's presence at birth which is in contrast to Chinese women's stated preference for their mothers or mothers-in-law.

Both societies in different ways have a patriarchal ideology and a general tendency to son preference in different degree (§3.1, §5.1, §7.1, §7.2). For the Scottish women the idea, of course, differs structurally that Scottish women bearing male children do not really achieve the same social status and financial gain in a family as Chinese women do. There is an indication in their verbal self presentation and articulation that the Scottish women are more emotionally attached to the child than Chinese women. Male preference was expressed by five Scottish women though in a less overt and less marked manner than by their Chinese counterparts. On the contrary most of Scottish women expressed their preference for having a girl on the basis that she could be more sympathetic to her mother's situation and care for her parents in their old age (§7.2) as a Chinese boy does for his parents.

The significance of having a child varies in different ways across social strata in both societies. Having a son is a source of status for a Chinese married woman in her in-laws' family. This is still pretty much so in rural China today according to Croll (1995, 1985a) (§3.1). Yet seven Chinese women in the study happened to have a girl and had no problem in accepting their baby daughter. The change in their attitude towards daughters implies that the Chinese women had adjusted to the host country's culture by making shifts in beliefs. The meaning of having children was transformed into an awareness of the responsibility of being a mother.

Childbearing for the Chinese women in Scotland meant an expansion of themselves and their family in an alien culture (§7.1) which is a form of compensation for the alienation felt. They had to learn to survive in the process of integration into the host culture. This process of cultural integration marked the experiences of most childbearing Chinese women in Scotland in the study.

10.2.2 Social organisation of family surrounding childbearing

Both Scottish and Chinese society traditionally have a patriarchal ideology in which men are the householders and in charge of the family while women are the 'house servants' and care for children (Jamieson 1997: 17, §5.1, ACWF 1989: 3-4, Wolf 1972, §3.1). It was the decision of the patriarchal family to have children they want. This was the very reason why some Chinese women in this study would prefer

to have their mother in attendance during the childbirth for protection of their own interests (§8.1.2).

The tension of the mother-in-law relationship was evident among the participating Chinese women but it was not evident among the Scottish women because the extended household is not common in Scotland and there is no sense of women moving into the women's 'in-law' family.

Chinese women continue to find themselves in a subordinate position in the family. This is why in the study I found that the Confucian doctrine of 'three obediences' prescribed to Chinese women historically has been transformed into the 'three-fold duties' (§3.1.6) of women in China today. Most Chinese participating women had a job of their own, either in China or in Scotland, but some still explicitly or implicitly expressed their submissiveness to the father before marriage and to the husband after marriage. Perhaps the best illustration of this is provided by the Chinese woman (W8), who expressed her unwillingness to have her husband present at her labour simply because her husband warned her not to embarrass him by losing control (§8.1.3). Such evidence further confirms the submissive social position of Chinese women documented by Croll (1995), Hall (1997) and other Chinese scholars (§3.1).

Some British sociologists (Jamieson 1997: 16, Richardson 1993: 3, Oakley 1980: 96) argue that households became more child-centred as mothers increasingly devoted themselves to their children (§5.1.5). Contemporary married British women are often earners as well as mothers (Jamieson 1997: 18). They have become more independent and career-minded outside the home. By doing so, some of them find difficulties in coping with the conflict between their social roles as a mother and an employee— a scene not dissimilar to the changed experience of Chinese women this century. Two Scottish women in the study expressed their feelings that by having a child their personal life may be satisfied but their career may be sacrificed (§7.1). For some of them, childbearing can demand difficult personal choices.

All the Scottish women in the study had jobs at some stage before their childbirth. Nine of the ten returned to the traditional idea of remaining at home giving domestic support to the family and planning not to take up a full time post until their children reach at least school age. Their deference to the partner is less strong compared with Chinese women. All the Scottish women I interviewed showed their independence in many matters of domestic, as well as public life. Romantic love or a partnership model is more evident in the conjugal relationship. One Scottish woman

went so far as to suggest an absolute equality between men and women in the family — in her case she felt there was no woman's place and man's place at home.

10.2.3 Childbearing as a social transition

Childbearing and childbirth are socially meaningful not only to the woman who gives birth to a child but also to the wider community concerned. How these meanings are constructed and expressed is the culture of childbearing itself in a given society (Gittins 1985: 67, Oakley 1980). Thus childbearing and childbirth are symbolically and ritually important in all human societies. The birth of a child is socially significant immediately to at least three persons in the society: the child, the mother and the father. The childbirth is a transition for all of them towards a new social status. Both Scottish and Chinese societies, in the past and present, have elaborate rituals to mark such a transition. This finding supports Homans' argument (1982) that all the women observed some rituals in different ways during their passage to motherhood to ensure the smooth transition from one social state to another, but it disputes Bastien's (1992: 32-33) view that rituals which honour this change are 'conspicuously absent' in the Western care models. The rituals which honour this transitional change in the Western care models could be found in a different form as in the examples illustrated by Homans (1982: 243-257) — prohibiting certain food, bending, stretching or lifting heavy objects, learning how to be a mother through antenatal classes, gift giving after the birth, etc.

For both Scottish and Chinese women the transition can be seen as involving cohabitation, marriage, conception, pregnancy, delivery, naming of the child and postnatal care for the mother and the new-born. Marriage and/or cohabitation in the UK are often the beginning of the transition to parenthood ritualised for those couples who choose to have children. Although extra-marital birth is still seen as undesirable in both Scottish and Chinese societies to varying degrees, single parenthood is increasing in Scottish society.

Successful conception is one step forward towards the social transition. The transition from one social status to another is a time of uncertainty. Childbearing is a time when the woman does not fit clearly within cognitive and social categories of being a 'mother' (Homans 1982: 254). Such uncertainty coincides with the unpredictable nature of the birthing process. These underlie the notion of pollution in childbearing discussed by Homans (1982: 254-255), Ahern (1978c), Dunn (1978), (§4.3.3, §9.4) in many societies, including traditional Scottish and Chinese societies. At this marginal state the woman usually has to abstain from certain activities and other

people have to take precautions before coming into contact with her because of the possible pollution she may inflict on them (Ahern 1978c:269, Homans 1982: 254-255). The Chinese and Scottish women in the study did not appear to be concerned with notions of pollution of women in childbearing, but they did try to cleanse the body by washing and bathing before and after childbirth.

For all the Scottish women and most of the Chinese women in the study, pregnancy and childbirth had brought joy, but at the same time worries. They worried because they were in a state of uncertainty about the birth of the child, about the health of their new-born and about their future roles as mothers. Childbearing was generally perceived by Chinese women in the study as a private business, a family matter, but in reality the birth of a child is socially significant. Because they are physically carrying the event forward, they felt the need for reconciliation between two domains, the private business and the social event. They seemed to be uncomfortable to talk about their pregnancy and birth in public. Holroyd et al (1997: 71), Davin (1976: 132) and Wolf (1972: 155) argue there is a culture of shame for Chinese women (§4.2.3) as childbirth reveals the sexuality and privacy of the couple. This culture of shame also explains why rituals and observances during childbearing were so important in traditional societies. However, none of Chinese women in the study felt shameful about their state of being pregnant and giving birth (§8.2.3).

In traditional Chinese society, people believed in 'foetal education' (§4.1.3). This was a step taken to prepare the child for culture and society. More than half of the Chinese women in the study followed the practice in one way or another, especially those from Taiwan. During pregnancy, they talked to the baby silently, listened to music and tried to remain calm and happy (§7.4.3). It is believed that in this way the child will be good natured and have a good personality. In Scotland today, there is considerable emphasis on fetal health through encouraging pregnant women to have a healthy diet and to attend antenatal classes, clinics and physiotherapy to prepare them for the event and their future role as mothers. As Homans (1985: 161) argues, there is always pressure on migrant groups to adapt to the ways of the host population and encourage them to comply with the local 'rites of passage', for example, the inappropriateness of antenatal care for Asian women reinforces an overdependence upon hospital and doctor (Homans 1982: 260). This can also be observed in the dependence of Chinese women in the study on the medical profession and their compliance with the hospital antenatal checks.

Birth is the beginning of a life cycle. Birthday celebrations of a year old for the Scottish babies symbolised this beginning. For the Chinese the first big celebration

is usually held 30 days after the child is born. The 30-day period of *zuo yuezi* (§4.3.1 and §9.1) is meant for the mother's recovery, as well as the care of the new-born. It was regarded by all Chinese participants as a way to protect them so that their bodily strength could be regained, though it might also imply a form of seclusion. Childbirth has physically completed the process of childbearing. So a period of 'confinement' for both the mother and baby is believed to help to bring the social transition of childbearing, the first rite of passage to life, to a successful end. More importantly, while the baby had been the centre of concern throughout pregnancy and birth, the mother had now largely become the centre in this one-month postnatal care. Her recovery from the laborious job of childbearing and giving birth was seen as essential to ensure the health of the new-born, future conception and birth. The Chinese *zuo yuezi* is echoed in many other cultures: Malaysians' 40 day seclusion, Mexicans' *los curenta* ('doing the 40'), the Ibo of Africa's 28-day seclusion, Colonial Americans' 4-week-lying-in (Bastien 1992, 1993), Indians' standard observances and rest of five weeks (Jeffery et al 1989: 149-169) and South Asian postnatal custom of rest in London (Woollett & Dosanih-Matwala 1990: 181).

Chinese women in the study, like all the other ethnic groups of women in the UK, have to adapt to new social roles and relationships. What is different in the rites of passage is simply how childbirth has been treated socially and culturally. The postnatal rest was recognised to be healthy and encouraged. The lying in time was taken as a time of promoting the women's reflection and bonding with their baby. In this sense, extended family involvement in childbearing has obviously its effect on Chinese women's social well being. Five Chinese women in Scotland in the study managed to have either their mothers or mothers-in-law come to Scotland for at least a short period after childbirth to make their transition to motherhood easier.

10.2.4 Different meanings and strategies in health in childbearing between Chinese and Scottish women

Three main areas of difference between Chinese and Scottish women emerging from the study are addressed here: (1) diet, (2) perception and tolerance of pain, (3) practices and beliefs of postnatal care and recovery.

The first major area of cultural difference identified in this study is about diet during childbearing (§7.4, §7.5, §9.5). Chinese ideas of health were built on the belief in the balance of the cosmological polarities of *yin yang* or 'hot' and 'cold' (§3.2.1). The balance of *yin* and *yang* ensures a successful conception and pregnancy. Chinese women tried to maintain the balance before and throughout

pregnancy through diet, rest and mobility adjustments to maintain tranquillity in the mind and the body and in their personal lives (§4.1.2, §4.1.6. §7.5).

With respect to diet, Scottish women in the study paid more attention to the well balanced diet in terms of protein, fat, carbohydrate, vitamins and minerals to ensure the health of the baby during pregnancy than after parturition. The quality of the breast milk mostly was not an issue which Scottish women worried about. Their diet did not seem to be seen as linked to the baby's health. The Scottish women in the study had confidence that their body could produce what the baby needed though some breast feeding mothers did worry about alcohol and foods that might cause baby colic.

Different meanings have different strategies in coping with problems during childbearing. Chinese women placed important emphasis on maintaining a cosmological dietary balance (§3.2.2, §4.1.5, §4.3.2) within their understanding in five ways: property of the food, its preparation, cooking, different ingredients and the taste of the food. Their stress on the balance of 'hot' and 'cold' of diet for maintaining health during childbearing was similar to that of South Asian women in Britain reported by Henley (1979), Homans (1982: 145, 245) and Bradby (1997: 219-225) and that of Indian women by Jeffery et al (1989: 77).

In the postnatal period all Chinese women in the study believed to various degrees that a cosmologically well-balanced diet could ensure sufficient lactation, good maternal recovery and prevention of future incurable disorders as the result of dietary imbalances during this period. The 'hot' and 'cold' balanced postnatal diets appeared reasonable and important to the Chinese mothers in the study. Most of them would do their best to apply these principles pragmatically and enjoy the symbolic implications of meaning and significance of the food as well as the nutritious values. Although some Chinese women in the study subscribed to Western nutrition theory, they supplemented it with the dichotomy of 'hot' and 'cold' food. It appears that medical care needs to be sensitive to Chinese beliefs and practices around food in childbearing.

The observances of the Chinese childbearing women in Scotland suggest a tendency to subordinate women's needs to the child's. This can be observed from the practices of 'fetal education', diet and mobility restrictions as a means of protecting the baby whereas the Scottish women tended to see women's needs including emotional ones as having precedence over those of the baby during pregnancy especially in terms of maintaining mobility and sexual activities.

The second major area of cultural difference identified in this study concerns the perception and tolerance of pain. The findings support the claim of Illich (1975: 93) that culture can make pain tolerable by integrating it into a meaningful system (§4.2.4, §8.2.3). The concern of shame (Wolf 1972: 155, Holroyd et al 1997) in losing self-control during childbirth transformed Chinese women's experience of pain in labour. Chinese women tended to expect and be less surprised by the pain of childbirth. Labour pain was assumed to be normal in childbirth. Though they often welcomed pain relief technologies, there was a Chinese cultural expectation for them to endure in silence.

There appears to be a positive link between the articulation of the experience of pain and the rising intervention rate among those who articulate it. Enduring silently is often taken by health workers as having a high pain threshold and results in less pharmacological, medical or surgical intervention. This may lead to the interpretation that the noisiest women may obtain the most attention while the quietest may remain unnoticed, as one health worker suggested. Scottish women's acceptance of medicine in childbirth, especially pain relief, is generally higher than that of the Chinese women from mainland China.

Chinese women had complex and somewhat contradictory inclination towards pharmaceutical pain relief. They were surprised to find that women's needs were seen as important with respect to having the choices of pain relief in labour (§8.2). They had a general desire to do what was 'normal' in the host country and to be one of the members of the host country but they were also generally suspicious of pharmaceutical analgesia because it was believed to be 'hot'. They were reluctant to accept painkillers, but at the same time in the absence of pharmaceutical intervention, they felt disadvantaged, deprived, alienated. They eventually accepted pharmaceutical intervention for pain control during the labour despite their conflicting feelings. These may be the reasons why the overall comparison in the study does not show much difference in the choice of analgesia between Chinese and Scottish women.

The third main cultural difference between Chinese and Scottish women concerns the recovery and care during the postpartum period. Postnatal *zuo yuezi* was adopted by Chinese women to promote rest to regain their strength and to avoid physical contacts with draughts, cold water, ice, cold food and some fresh vegetables and fruits after delivery (§9.1) and to achieve a somatically well balanced postnatal diet (§9.5). The value placed on rest, recovery and the perceived vulnerability postnatally of the Chinese women is similar to that of South Asian women in Britain reported by Woollett & Dosanjh-Matwala (1990b: 181) but the customs of *zuo yuezi* are much

elaborate. Scottish women's health is protected less well than Chinese women in postpartum because of expectations of greater socialising and mobility. Scottish women would see the social restrictions on Chinese women as restricting their freedom, but two of them also expressed their envy of the rest which Chinese women *zuo yuezi* get.

The physical change in the body and the pressure to adapt to the new roles and new relationships as a mother may be amongst the causes of what is commonly known as 'baby blues' or postnatal depression (§5.3.3, §9.8). The experience of pregnancy, birth and caring for a child everyday can be exhausting, lonely and isolating, as Boulton (1983, Oakley (1980) and Richardson (1993) suggested (§5.1.5). Postnatal depression (§9.8) is a new concept for some Chinese women as their custom of *zuo yuezi* places them in the centre of the family after childbirth. Most Chinese women in the study did not experience 'postnatal depression', suggesting that this is very much culturally and socially specific. This can be further illustrated by the example of a Chinese woman who experienced postnatal depression with the absence of her mother's attendance in her *zuo yuezi* (§4.3.1, §9.1, §9.2) and another Chinese woman who did not experience baby blues and started to worry that she was not normal.

Childbearing is a unique journey for a woman, during which she transcends one social status to achieve motherhood (Homans 1982, Yearley 1997: 25, Helman 1997: 168). In this process of social transition the women in the study were expected to cope with a new role along with a variety of others: lover, girl friend/wife, mother and a worker. The transition of Scottish mothers was facilitated by the midwife and the women's network to adjust to their new status while the Chinese were, additionally, smoothed by *zuo yuezi* (§4.3). There seems to be a greater emphasis by the Chinese on Chinese women's health and well being during the postpartum period via 'sitting in for the month' and postnatal diet for Chinese women indirectly to ensure the health of the baby. For Scottish women the focus is more heavily on the child's needs directly rather than through the health of the women. The focus of Scottish women's recovery in this period was in the sense of regaining body shape rather than their own health in relation to the health of the baby although they did get dietary and exercise advice oriented to recovery. The phenomenon of 'baby blues' indicates concern with the psychological health of the women and their experience of isolation, lack of social support and overwhelming social expectation and responsibilities.

The three areas of differences identified above illustrate how the participating women selected alternative coping strategies according to their cultural understandings

to interact with the health system in which they are permitted to optimise their valued choices and controls. Different emphasis on woman's and child's well being through issues of diet, rest and other activities represents different social and cultural background of the woman. Lewin (1985: 123-138) views that women are not passive recipients of circumstance but active strategists who use both traditional and alternative health care systems in the course of becoming and being mothers. My findings expand on Lewin's view that women's active measurements and strategies in response to circumstances are based on their cultural background. Knowledge of the significance of these differences can facilitate an understanding of the cultural and social links between a woman and her environment and bring us closer to an understanding of how she operates strategically in her childbearing.

10.2.5 Chinese women selectively follow Chinese and Western medical practices

Compared with Chinese women, Scottish women in the study, overall, followed medical advice more closely, and believed medical knowledge more readily. Chinese women drew on traditional alternatives and beliefs while accepting medical knowledge to some degree. Although Chinese women showed deference to medical authority in the new social environment, at the same time, they adhered to many aspects of traditional Chinese notion of health. This was most evident in relation to food and diet where Chinese women largely but not entirely ignored medical or nurses/midwives advice. Although they had to adjust, to a greater or lesser degree, to the practices in their new environment, the Chinese women presented a strong desire to maintain their therapeutic culturally oriented dietary habits and rest patterns in relation to childbearing.

Western medicine and midwifery practice have changed the birthing practice of Chinese societies in this century, especially in urban China, but the use of medicines in normal labour, for example, pain relief (§8.2.3), is still seen as unnecessary by many Chinese people. At the same time, Western medicine divides the Chinese, with the urban and the educated Chinese in favour of the new medical technology and the rural Chinese adhering largely to tradition in childbearing. But the division is not so clear-cut. The rural and working-class Chinese women in this study were attracted by the ideas of painless and short labour, and felt privileged to have the benefit of free medical care in Scotland, while some of the urban Chinese women revealed a growing feeling of loss of control in their medicalised childbirth, as some Scottish women did. They were trying to revive and recreate what they find still meaningful in the practices of traditional notions of health and childbearing. Chinese

participating women increasingly accepted hospitalisation of childbirth, pharmaceutical and surgical intervention for pain relief and the concept of mobility before, during and post parturition as the result of the influences of and pressure from the main stream practices. These indicate the blending of Western and Chinese approaches by Chinese women in Scotland.

The participating educated Chinese women from Taiwan, a much more 'westernised' Chinese society, had a strong tendency to resort to the traditional notions of health practices in childbearing in terms of their consciousness of pregnancy vulnerability, fetal education, observance of balance of hot and cold food, postnatal rest and taboos. Some traditional practices have been consciously or unconsciously incorporated into their ways of life. All Chinese women in the study, including those from mainland China, still observed the culture surrounding food intake and mobility in childbearing to various degrees. They paid particular attention to the balance of 'hot' and the 'cold' food during pregnancy and particularly after childbirth. To various degrees they avoided draughts, drinking cold water, bathing, washing hair and mobility after birth in order to facilitate their recovery and prevent future unpredictable aches and pains. They interpreted some medical and midwifery advice on mobility, washing and bathing to facilitate wound healing and recovery after child birth as only relevant for Scottish women (§9.1). In other words they viewed their own requirements and practices were different. There were tensions and differences between Chinese women in how much they adhere to traditional Chinese views, how much they resist Western views and how much they blend both.

Chinese women tended to want to do what is deemed 'normal', on the assumption that what is normal is the safest, though this might also be seen as an immigrant strategy for 'fitting in' to the host country. Chinese women's greater deference to authority tended to compound the above and was very evident in their divergent attitudes to midwives and doctors. They did not associate a midwife's attendance with any sense of normality, or women's solidarity and bonding in the ways Scottish women did. They did not associate a doctor's attendance of their childbirth with any sense of abnormality but with prestige. They felt intimidated by the high-tech and alien medical culture. By contrast, Scottish women were aware of the relationship between doctors and midwives. Midwives to them are clearly better trained to interact with women and deal with normal deliveries, while doctors are trained to deal with abnormal situations when things go wrong. A sense of reliance on medical staff was more marked among Chinese than Scottish women, although both groups of women tended to err on the side that obstetric staff know what they were

doing and to accept their judgements and interventions without much questioning. These reflect their different attitudes to health workers and to the use of technology. This makes it particularly significant that Chinese women contradicted medical and midwives' advice so dramatically in their approach to diet in labour. It is also notable that these women's strategy was posited on assumptions of a normal birth, where medical advice was posited on assumptions of danger (§5.2.1, §7.3, §8.3).

The experiences of Chinese and Scottish women having babies in Scotland support Jordan's argument (1978: 67) that birth 'constitutes an object for systemic consensual shaping and cultural patterning in human societies'. What she meant is any way of doing birth consists of beliefs and practices which are mutually dependent and internally consistent. Different groups of people have developed different ways of coping with childbearing even within the same birthing system. The meanings of childbearing of any one ethnic group within this system will depend on how well their own cultural system and resources fit with the existing socio-political realities and ideological system of its time and place.

Childbearing is surrounded by rules, customs and prescriptions in different ways for Chinese and Scottish women. The focus on the meanings of having children illustrates the different social experiences of the childbearing women. Their experienced reality has revealed tensions and changes in how childbearing is constructed in each group. The empirical knowledge of these two groups of women directs our attention to their health needs in childbearing in terms of their diet, pain relief, rest, and their postnatal avoidance with bathing, washing hair and contact with draughts, etc.

The diverse cultural meanings of childbearing presented in the preceding pages illustrate a dynamic process of conceptualisation of childbearing both at individual and institutional levels; and at practical and symbolic levels. The claims of culture as 'a way of life' (Leininger 1978: 112), 'a patterned behavioral response' (Giger & Davidhizar 1995: 3) emphasise the stabilising features of a culture that provide the group ready-made solutions to their life problems and resistance to changes. The dynamic qualities through time and place of a culture are underplayed in these arguments. At the level of theory, the concept of culture is being expanded as 'multiple discourses', 'more often coexisting within dynamic fields of interaction and conflict' (Dirks et al 1994: 3-4), especially when it is in contact with other cultures (Henley & Schott 1996). These dynamic features are visible in the examples of some Chinese women in the study who tried to identify themselves with host people. These can also be observed through some Scottish women who tried to increase their control

over their childbearing. This feedback relationships between these different practices were significant for the overall shape of the Scottish cultural childbearing system.

The diversity and fluidity of the women's childbearing experiences revealed in this study challenged the rigid and timeless transcultural nursing models of patterned behaviour and expressions within a cultural group, which is further discussed in §10.5. However, these timeless traditions or models to some extent, turn out to have been 'invented' (Hobsbawm & Ranger 1983, Dirks et al 1994). They are different from those practices in the areas the women originally came from.

10.3 Choice and control in the medical institutions of childbearing

The belief systems of different cultures contribute to the cultural and social significance of health in childbearing. As pointed out in §3.2, §5.2 and §10.2, childbearing is institutionalised in all human societies precisely because it is culturally and socially significant. Modern medically based maternity services and the related obstetric technologies are but one form of the institutionalisation of childbearing. In this thesis, through the study of the institution of childbearing in Scotland, the participating women's experiences of this institution and my own experience, I believe my study confirms the existing literature that the institution of childbearing is the battle ground on which power is fought for in the control of the knowledge of health and childbearing between women, midwives and medical professionals. The hospitalisation of childbearing in modern industrial societies creates complex hierarchical relationships between the professionals and women in childbearing. This relationship is expressed in the form of 'control' and 'choice' between and among all parties concerned (§5.3, §8.1). The issues of choice and control are further discussed in the following two sections:

10.3.1 Women's ambivalent feelings about medicalised childbearing

All the women in the study faced an unfamiliar environment in hospital. Chinese migrants were much less familiar with the health and maternity care system. They were therefore even more anxious and more dependent on professional expertise, and technology, and had to comply with the hospital routines. Generally, the Chinese and Scottish women in the study showed different degrees of deference to maternity professionals and to their authoritative family members. All Scottish and Chinese women felt safer giving birth in hospital but they tended to have different attitudes towards childbirth. Chinese women tended to want a 'normal' birth, which to

them meant to have a trouble free delivery and to fit into the prevailing medical model, while many Scottish women wanted a 'natural' birth, that means a more active role and minimal medical intervention. By implication, this means a trade-off between women being safe and women being active — a trade off in which technology plays a key role (Ch 8).

Many women in the study wanted to believe that their bodies were able to give birth to their child with minimal or no analgesia. Intervention in childbirth was not normally welcome but all women felt reassured when the monitoring technology was there for them to see their babies and hear their babies' heart beats which confirms the findings of Evans (1985), Oakley (1984) and Neilson (1995b) (§5.3.1). When they were experiencing pain in labour, they would accept pain relief. All the women in the study seemed unaware of the implications of the use of pain relief, especially epidurals, which often lead to a cascade of intervention in birth, as some women in the study have experienced (§8.2.2, §8.2.3). Health workers had apparently failed to get the message across to the women. A 'safe childbirth' in the logic of medicine's emphasis on technological intervention overpowers women's beliefs that their bodies are capable of giving birth to their children. Women who fell into such a trap in childbirth find themselves in a contradictory situation— losing control in the process of labour.

Historical studies of traditional childbearing (§4.2, Ehrenreich & English 1973, Tew 1990, 1995) and my personal experience in China have shown that traditional birth attendants/ midwives or female relatives were mostly older and 'experienced' women who had given birth to children of their own. In other words, they knew from experience what should be done and what should be avoided to ensure a safe birth. In combination with the notion of health in Chinese medical culture, the rules, observances and taboos for childbearing formed an institution of childbearing in a given society, although these were loosely organised in comparison with those of modern hospitalisation of childbirth. In this sense, modern midwives are not different from individual traditional birth attendants. They differ only in the cultures they represent, in the ways childbearing is organised, and in the nature of expertise and authority which each wields. Women in labour are reassured by the accumulated experience of their carers, which for them is embodied in the hospital and technology. From this point of view, we are able to understand why most women, both the Scottish and the Chinese, as the study has shown, continue to opt for hospitalisation, though they view its significance in different ways.

Previous studies (Donnison 1988, Ehrenreich & English 1973, Faulkner 1985, Oakley 1976, Shorter 1982, 1983) have clearly indicated the power hierarchies or tensions between and amongst doctors, midwives and women in the course of childbearing. In the study, these power hierarchies and tensions between the professionals have also been sensed by the childbearing women (§8.4.1). Such evidence of professional rivalries has further indicated that the power hierarchies and tensions in childbearing between doctors and midwives have affected directly women's experience of childbearing. In such instances professional rivalry is often acted out at the expense of women in childbearing. These rivalries may have contributed to the ambivalent feelings of women about medicalised childbirth. They also confirm that medicalisation of childbearing has in fact led to the power imbalance in childbearing between the professionals as well as between the professionals and women. Medicalisation of childbirth tended to create a situation in which women had been made to feel dependent on professional expertise, which further strengthened the power imbalance in childbearing. Women's bodies and babies are in effect at the centre of all professional attention and they are also at the centre of a women's search for their identity and for control.

The maternity service and obstetric technology in Scotland were attractive to most Chinese women in the study, even though they might have felt alienated from time to time. One Chinese woman remarked that 'hospital [in Scotland] tells you most of the things, so you don't feel the need to rely on domestic advice' (§8.3). From this, it can be argued that institutionalised childbirth is not really the main problem. The problem is very much how childbearing is institutionalised. In other words, the question is how 'experts' see and organise hospitalisation and what the relationships between women, the maternity professionals and obstetric technology are.

10.3.2 Control and choice are more complex issues than assumed

Control and choice are very difficult issues in practice as is demonstrated in literature (Green et al 1988, 1990, DoH 1993a, Mander 1992, 1993a & b, Sandall 1995). The concept of 'control' for women in childbearing culture can be summed up as self-control over one's own behaviour and control over what is happening or being done to one (Green et al 1990: 16). Choice means decision-making.

Green et al (1990) examined the issues of choice and control in the sense of the link between women's expectations, decision making and psychological outcome after childbirth. They raised the professional arguments that women cannot cope with the responsibility choice carries (Mander 1993: 23), which may lead to self-blame,

guilt and depression for some women. Although they acknowledge the complexity of the issues of choice and control in their study, Green et al have not related their findings to those arguments directly. Their contentions are that expectation of being in control were positively associated both with achieving control and with higher satisfaction. Information and feeling in control were also important to women's subsequent emotional well-being.

Many critics are wrestling with the debate of control and choice. Based on literature research Mander (1993: 24-25) argues information giving is crucial in the context of making choices and exercising control. Her findings are women do not have much control as 'the carers are still retaining the ultimate sanction — which choices will be available to the women'.

My investigation looks further into these two categories from an interpretation of culture as the construction of power and from the relationship among the hierarchical division of the social 'actors' of women, women's body, baby, professionals, obstetric technology and wider social context (Fig 5, in the later part of this section). The rhetorical emphasis on consumer choice is a device for the childbearing women to challenge unacceptable professional power and obstetric technology, to question medical iatrogenesis (Illich 1975) and at the same time a strategy for the public, media and the state to question and to control the effectiveness and efficiency of medical care. These can be observed in the Changing Childbirth report (DoH 1993a) and Figure 5 in this section.

In Scottish medicalised childbearing, there is a tendency for women's knowledge to be dismissed. Although completing or writing a birth plan by women themselves has become part of the practices offered in the maternity service in Scotland, the majority of women in the study did not really feel their birth had been planned by themselves. For Chinese women, this was even worse, adding to their language and cultural difficulties. Their plans were generally not read and discussed with them by midwives before admission for delivery.

The sense of being in 'control' was felt to be illusory by the parturient women in the study because usually they did not feel their childbirth progressed as they had planned. Many went into their child's birth with an assumption of normality and came out with a feeling of losing final control of the birth to some extent. The scene of childbirth became a place where they confronted these conflicts among mothers, midwives and obstetricians. There was little evidence from this study to

suggest that hospital delivery would result in women being able to assert greater control over their bodies.

My data about birth plan (§8.1.1) and birthing positions (§8.1.4) highlight the strong sense that neither women or health workers are in complete control, and that the rhetoric of choice is misleading. The political rhetoric of ‘woman centred care’ (DoH 1993a) is an indication that more consideration was demanded by women to be given to their views. There is obviously a gap between what women see and demand from maternity practices and what has been on offer in maternity services.

Technical management of childbirth has been historically developed and shaped by the culture and the ideology of medical professionals (Wajcman 1991: 56, 71). However most literature reflects the control of medical and midwifery professionals, and their technology, over the women’s experience of childbearing, childbirth and childrearing (Kitzinger 1977, Kitzinger & Davies 1978, Oakley 1976, 1984, Faulkner & Arnold 1985: 1, Oakley & Houd 1990, Sandall 1995, Green at al 1990). On the basis of this study, I would argue that the social relationships which can be seen as regulated by ‘control’ and ‘choice’ are far more complicated than is implied in much of the above-cited works.

In general, the metaphorical social forces regarding choice and control in childbearing can be deconstructed into five different ‘actors’ — women, their bodies and their baby, health professional, obstetric technology and wider social context. The relationship amongst these five different types of ‘actors’ can be summarised in Figure 5:

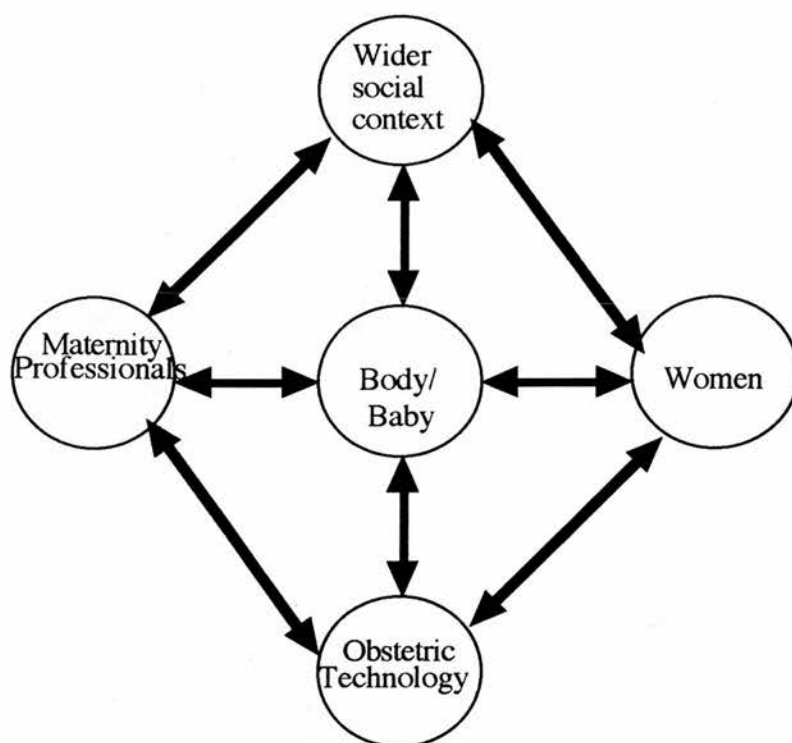


Figure 5: The relationship amongst the five social 'actors' in medically institutionalised childbearing regulated by the cultural categories of control and choice

As Figure 5 shows, human 'body' and baby are in the centre of all the relationships on the issue of childbearing. It is mainly through the human 'body' of the woman and 'baby' that the other social 'actors' exercise 'control' and 'choice' in childbearing. These different types of 'actors' are wrestling with and produce these binary social relationships which are mutually dependent and internally consistent. What makes them dependent and consistent is the local culture's specific definition of childbearing and locally shared views regarding the issues of choice and control.

At this point, one should also point out that control and choice are Euro-American socio-cultural categories which do not appear in either historical or contemporary Chinese birthing culture. The Chinese have other categories for regulation of the concern for the body of the new-born and the mother. The safety of the mother and the baby, for example, is the main focus in Chinese childbearing, although the issue of 'safety' in Britain is of course also present and sometimes takes precedence over concern for 'control' and 'choice'. It should also be noted that even when 'control' and 'choice' become cross-cultural categories, they will regulate different social relationships and have different implications in these relationships in different societies and cultures. For example, in pain relief in Chinese birthing culture, as discussed in the study, 'control' is also an issue. Women are encouraged mainly to have self-control over their behaviour in coping with labour pain. But in Scottish

childbearing culture women focus on expecting to have control over what is happening or being done to them. They expect to have a choice of analgesia or epidural and thus to be under control of obstetric technology.

All five different types of social 'actors' discussed above can be identified in any societies, but they will be different in different societies. Thus the approach of the maternity professionals in a Chinese society will be different from that of the maternity professionals in a Scottish society, and so on.

The two-way arrows in Figure 5 indicate that all five social 'actors' are mutually related to the issues of 'choice' and 'control' in childbearing. These relationships in fact have been the focus of my concern in the whole thesis, that is social and cultural shaping of childbearing in Scotland among Scottish and Chinese women. The five social 'actors' and their relationships constitute what I have suggested is a social and cultural construction of childbearing.

'Wider social context' in Figure 5 refers to the community and social institutions in which childbearing has to take place. All social 'actors' involved are sanctioned by the 'wider social context' in matters of childbearing. In this case, 'wider social context' is in control of childbearing and at the same time makes and provides choices in relation to other social 'actors'. In the study, the social and cultural meanings of having children and the social and cultural construction of notions of health are the examples of society exercising some control and providing choices for women in childbearing. For individual women, there are traditional rituals, religious and food observances (§3.2.2, § 4.3.2, §7.6 and § 9.7), traditional ideas of pregnancy dangers and pollution (§4.3.3 and §9.4) in childbearing. Chinese women bearing children in Scotland were clearly subject to controlling influences of the Scottish community and made choices in this community. They have to follow the legislation and customs here in giving birth to a child. The social and cultural meanings of having a baby to them are no longer the same as those of having a baby in a Chinese society.

The other four social 'actors' in childbearing are also part of the larger community. In this sense, they also exercise some control and provide choices to the society at large in matters of childbearing. We can say that the operation of a particular type of maternity service determines the approach and the manner of childbearing in the society. Maternity professionals are therefore more directly in control of childbearing in relation to the community at large.

There are the different types of social 'actors' in childbearing. 'Control' and 'choice' are the social issues relating all these social 'actors'. Therefore it is not the question here whether these 'actors' should have 'independent wills' of their own in order to exercise 'control' or 'choice' over other 'actors'. It is rather the question of the status of these social 'actors' in such relationships. It has been argued that human 'body' and 'technology' are socially and culturally constructed. The socially and culturally constructed notion of health and technology influences people's behaviour in a given society. It is true that technology has been created through the human mind, but once technology is created, its use has material consequences and shapes human behaviour in specific contexts.

In the last three decades, the debate on the issue of 'control' and 'choice' has been focused on women's right to choose to control their own bodies (§4.2.4, §5.2, §5.3, Ch 8). The issue in this debate tends to get simplified. Choice implies a comprehensive set of options on the parts of all the five social 'actors'. An options which was taken by each 'actor' would mean the loss of control by the others; but at the same time, an option would also mean a consensus from the others, which is a control. For example, the choices offered in maternity hospitals limit and control the range of women's choices. Therefore 'control' and 'choice' are related to all the social and cultural 'actors' in childbearing (Figure 5). There is not any one centre of power or control. Everything is in a dynamic relationship of constant negotiation or bargaining.

The discussion of 'control' and 'choice' is linked to the issue of 'autonomy'. 'Autonomy' in childbearing is not synonymous with 'control' or 'choice'. The question of autonomy is the question of information retained by different social 'actors'. The possession of information of each 'actor' increases its power of self-governing or control. 'Control' and 'choice' can also be seen as professional commodities (Mander 1993a, 1993b) in order to face the problems arising in modern obstetric technology and hospitalisation of childbirth. Undoubtedly, the advances in technology and hospitalisation of childbirth have transformed the diagnostic methods and the treatments of childbearing. These advances at the same time have altered the experiences of women and their relationships with the other social 'actors' (see also Wajcman 1991: 70). 'Control' and 'choice' are therefore useful tools for all to manipulate such changes.

While some Scottish and Chinese women were more ready to accept medical and surgical interventions without much questioning, others were alert to issues surrounding the use of medical technology and questioned how much they should

allow technology to control their bodies. Chinese and Scottish women alike to different degree believe that their body and the baby exercised significant control over the course of the birth. Scottish women were more interested in alternatives such as 'natural birth' or domiciliary deliveries. Chinese women were more interested in 'normal' childbirth. These findings have significant implications for the provision of maternity services in Scotland.

The feeling of being in control is linked to a better emotional outcome, which supports Green et al's findings (1988, 1990). It is arguable that the main contribution of this study to the literature of choice and control is to highlight the sense many women conveyed that to a considerable degree their bodies and that of the baby exercised significant control over the course of the birth — often irrespective of their wishes or the interventions of doctors and midwives. The other literature acknowledges the complexity of choice and control issues, but arguably has not given the same attention to bodies as this study does. In terms of practice this means that midwives should be counselling women to follow their bodies and the baby and assisting them to follow selectively sometimes medical advice and other times more traditional practices with which they are more familiar and comfortable to exercise their control over the birth and other aspects of childbearing.

10.4 Chinese women as an ethnic minority in the NHS in Scotland

Living in Scotland forces the Chinese to examine their preconceptions and to adopt both new social and new economic roles. They have to meet two sets of cultural expectations in their social life, that of the dominant culture and the culture of their own communities. In a sense, the Chinese in Scotland tend to be not only bilingual, but also bi-cultural. The memories of what they were familiar with in the homeland left behind often rekindled a desire to recreate the abandoned way of life. They reconstruct what was familiar to them to cope with changes and challenges in the new social and cultural environment. With this 'invented' tradition (Hobsbawm & Ranger 1983), they manage to compensate for the feeling of loss resulting from migration, which would otherwise uproot them from the social and cultural beings they originally were (§6.3). The process of reconstruction of their past experience becomes an important source of their conception of themselves, their comfort and part of the knowledge required of them socially and culturally.

There were two differences between urban and rural Chinese women in my study. The first was their attitude towards health, childbearing, beliefs and behaviour.

Urban people were more open minded to things happening around them, while rural people were more cautious and suspicious. The second difference was their levels of education. More and more the educated especially the urban Chinese women in Scotland, were attracted by Western medical approaches, but on the other hand their acceptance of new technologies continued to be moderated by their original culture and traditional notions of health and medical care, even though they might not be conscious of this happening. The evidence in this study indicates that reconstruction of women's childbearing experiences in the new social setting takes place mostly among this group of women. The less educated rural Chinese women tried to cling to their original beliefs and ideology. They would accept some medical services provided but would abandon others.

As noted above, the attitudes of Chinese women in the study toward health institutions and health professionals were different from those of Scottish women. Chinese women were surprised to find that the NHS was there as a free comprehensive service to them while Scottish women felt that they had a right to the NHS service and were more critical of the present maternity service. Chinese women had more confidence in medical staff than Scottish women did. They associated a doctor's attendance of their childbirth with prestige and a better service and tended to accept medical authority without much questioning. The Chinese women's behaviour was related to their cultural expectations of the Chinese society (§6.5). As argued above, old and experienced midwives convey a sense of authority and security about childbearing in traditional societies which has been translated by the Chinese migrants into a sense of security in the medical hierarchy of Scottish hospitals.

The more westernised Chinese women, like the Scottish women, tended to consider obstetric technology reassuring in terms of providing them with confidence and security for themselves and their babies but also threatening in the sense that technology might reduce their control over their bodies and their birth. The more traditional Chinese women seemed to be inclined to draw on non-medical resources and not so ready to accept obstetric intervention. However Chinese and Scottish women in general tended to consider that health workers knew what they were doing and tended to accept their interventions. The relationship of choice and control amongst health workers, women and their new-borns was the conflict of different social expectations and the struggle for control (§10.3.2). The conflict and the struggle for control are of course on an unequal basis. The differences between and within Chinese and Scottish women also show their different degrees of compliance with health workers and obstetric technology.

According to the maternity service providers in Scotland, antenatal education is good for women in general, but the findings in the study did not support this entirely. Two Chinese and two Scottish women did not attend antenatal classes at all. Two found them boring and one Chinese woman found them excessive and did not have enough opportunity to talk about and share experiences with the others. This may be partly due to inadequate command of English and partly due to cultural differences and cultural barriers, which prevented this group of women from appreciating and making full use of this service. Some insensitivity to their needs was felt by some health workers and Chinese women in terms of supplying the educational information in Chinese and providing interpreting services on demand. Nevertheless, Chinese and Scottish women had a record of full attendance of antenatal check-ups, not necessarily for physical or medical reasons but mainly for psychological reassurance and social compliance.

The different practices post parturition between these two sets of women illustrate their ambivalent feelings about medicalised childbearing, different strategies in their recovery after childbirth through increasing their mobility or rest, body cleansing, dietary issues, and issues of choice and control. Scottish women have inclined to follow health workers' advice to mobilise as soon as possible after birth, while Chinese women followed their tradition which stresses the importance of balanced diet in term of hot and cold, and rest to recuperate from birth for the first month as the South Asian women did in Britain (Woollett & Dosanjh-Matwala 1990b: 181). They avoided contacts with draughts, cold water, washing hair and bathing (§9.1, §10.3.2). These different customs and practices are associated with different values and meanings of birthing practices.

The institutional racism in health care was a major obstacle to equal access and equal treatment (Atkin & Rollings 1993, Kroll 1990). Although institutional racism is often invisible (ibid, §6.4) , it exists in everyday lives of people. The Chinese women in the study did not verbally identify that they had encountered racism but this does not necessarily mean they were cared for as well as the Scottish women overall. The criteria to identify the measurement of 'adequacy of care' could be different as different women are likely to value different types of care. An obvious case for Chinese women is that getting the right food at the right stages of childbearing is clearly a vital aspect of care for them — whereas medical and midwifery staff do not tend to see feeding as part of the care they provide. The insistence on iced water to drink and washing after the labour could also be read as another failure to care appropriately.

My study further supports the argument that health workers in general find it difficult to distinguish acceptable differences from unacceptable inequalities in regard to policy making and treatments because of limited resources (Klein 1988: 3-20, §6.5). This clinical distinction is thought to provoke discrimination against the others as to single out the needs of one group of people will divert the resources from the others (Klein 1988). The logic of this debate cannot ignore the fact that equal resources do not eliminate different fundamental needs, and different appropriate clinical treatments do not preclude the same resources. However, the mainstream health system has gradually come to accept the idea that a variety of social and cultural factors contribute to health status (Ahmad 1993, Nazroo 1997a & 1997b).

Although cultures of childbearing of Chinese and Scottish women have their distinctiveness, they need not be mutually exclusive. As the study has largely shown, Chinese women in Scotland were quite aware of the differences between childbearing cultures, i.e. that of their own and that in Scotland. They felt the social pressure to fit in the 'norm' in the host culture even to the extreme of wanting to experience postnatal depression in one case, but at the same time they tried to maintain what in the original cultural practices was still meaningful to them in the new social environment. For example, aspects of the biophysiological process of childbearing can be quite sensibly expressed through the concept of balancing in traditional Chinese culture. Doctors were interpreted into the authorities in childbearing rather than midwives because of their social positions. Doctors were even more authoritative than mothers and mothers-in-law, to whom Chinese women traditionally turned for advice in childbearing. This sensitivity and translation between cultures on the part of the Chinese women as an ethnic group in a new culture suggest what has been going on in the process of cultural integration in Scotland.

The study has revealed the diversity and different needs of these two groups of women. It has also provided some explanation as to why the differences exist in term of health beliefs, health practices and expectations of the health services. These cultural differences in the conception and interpretations of childbearing have reflected a different way of thinking and a different logic of an alternative rationale and health behaviour. These findings confirm Phoenix's (1990: 295) argument that they are not 'special' but 'fundamental' needs to the women using the maternity services. In a multiethnic society these needs have to be met in a variety of ways. The infusion of different ideas, customs, cultures and practices from this study into the Scottish obstetric culture can enrich life at the conceptual level; and promote a better

understanding and awareness of a different pattern of disease and health behaviour at the practical level.

Chinese and Scottish women continue actively to construct meanings around their health in childbearing in terms of their own identity, their views of their health, themselves and their bodies. Such knowledge will go some way towards facilitating the NHS to meet the psycho social and health needs identified by Ahmad (1992: 7) and Nazroo (1997a & b: 258).

10.5 Implications for practice and research

It is argued throughout this thesis that childbearing experience is culturally and socially constructed at individual and institutional levels. Different meanings in childbearing offer women and maternity organisations different strategies and practices. These meanings are grounded in their different cultural origins and are differentially related to people and groups in different social positions and the ways in which these cultural worlds interact. These cultural meanings exist within the dynamic of interaction and conflicts, which are more often in the process of changing. This changing feature becomes more marked in the confrontation of other cultures.

The dynamic nature of Chinese and Scottish women in the study illustrates the fluidity, diversity and complexity of human beings on health, childbearing, illness behaviour and their needs. The transcultural models (Leininger 1978: 39, Giger & Davidhizar 1995: 5-17) are helpful to discover the scope of diversity but have a tendency to assume that other cultures are homogenous and static because these models tend to lead to a rigid view of 'scientific' or patterned cultural differences between different groups and encourage stereotyping inaccurate information about other groups.

This rigidity can be further analysed through an example of the sense of Chinese orientation to time, one of the six cultural phenomena in Giger and Davidhizar's transcultural assessment model (1995: 9, §1.2.4). Chinese orientation to time according to their model is not past, present or future oriented (Chang 1995: 403). It is regarded as a dynamic wheel with circular movements and the present as a reflection of the eternal. In my view this is true traditionally to some extent that this dynamic wheel continually rotates in twelve year animal cycles and sixty year *jiazi* cycles in Chinese culture. This circular movement symbolically emphasises the focus on the completion of a task at present, and guides people to seek a harmonious relationship with their surroundings. This concept of time as far as I can understand,

has been changing in the younger generations, who are predominantly present time oriented. This can be observed in some of the Chinese participants in the study. They showed their concerns on their prolonged waiting time to see their GP (§7.8). This clearly illustrates their emphasis on schedules, promptness and synchronisation with clocks. On the other occasions they did not adhere to their appointments (§2.3.2). Their perception of time in my view changes in different situations and in the process of growing up and ageing as well. The young people tend to be more or less future oriented and the old people, past oriented.

The transcultural nursing models have their limitation and problems just as Schott & Henley (1996: 121) argue that 'general information about different cultures and religions tells us little about the person in front of us'. My analysed data support this view of 'individual approach' and clearly highlight the need to understand how childbearing practices are dynamic and the need not to take a rigid view of the requirements of any one group. A holistic cultural assessment of an individual's total cultural context and social environment tends to offer multifaceted aspects of human behaviours in response to environment and changes. This assessment can be achieved through learning some basic different cultural meanings and communicative skills (Schott & Henley 1996: 121-125). The basic professional training, the post basic educational opportunities and continuing professional development training can further facilitate the achievement of these understandings and skills.

According to the findings of this study, I want to discuss briefly in the next few pages some possible practical implications for practice, education and future research.

10.5.1 Practice

In practice, the health providers should be aware of the substantial differences in the notion of health, social and cultural expectations between Scottish and Chinese women (§3.2, §5.2). This may be reflected in their choices of medication, food, bodily cleansing and contacts, and mobility. For example, Scottish women would choose to use folic acid, vitamins and iron tablets in pregnancy and analgesia for pain control in labour, in contrast, most Chinese women would avoid doing so, when they could. Some Chinese women in the study subscribed to the theory of *yin* and *yang* and believed that food had *yin* (cold) and *yang* (hot) quality (§3.2.2, §4.1.5, §7.5, §8.1.5, §9.5, Chang 1977, Unschuld 1976 & 1985, Chang 1995: 406) and was part of care and treatment of illnesses. The others subscribed to Western medical nutrition model or both ways of thinking (§7.5) in a similar way as

Glaswegian Punjabi women (Bradby 1997:229). The health worker should be aware of this and help them choose the appropriate food according to these beliefs. This means the diet provided for them in the NHS should be sensitive to their needs in terms of choice, quantity, quality and concept of balance. The hospital dieticians and catering staff need to find out a good range of acceptable and feasible menus in order to meet the needs of their clients (Schott & Henley 1996: 140).

The study shows that language is certainly an obstacle in effective communication between maternity professionals in Scotland and Chinese women, especially the new comers, but more importantly lack of cultural understanding adds to the difficulty. Some dissatisfaction of the Chinese women in the study with GPs may result from language obstacles. Some understanding of the Chinese can reduce such difficulty. If an interpreter is needed, the dialect the woman speaks should be identified first as there are many dialects spoken that are not understood by other groups of Chinese. A child interpreter should be avoided because it is harmful for family cohesion and parental control of the child. The same information about childbearing, about provision of services should be made available to all in the language that the target population can understand (Woollett & Dosanjh-Matwala 1990b: 183). Language should never be a problem that prevents anybody from having access to information about their body, their labour and their choices.

For most Chinese women, maternity hospitals in Scotland are better organised and equipped than those they know of in their home country. Therefore for them, like most Scottish women, hospitalised childbirth is not the problem. But many Chinese women know little about the routines, practices and personnel of Scottish maternity wards. More explanation, where communication permits, is needed for Chinese women before their admission.

But just as there are differences among Scottish women, there are differences among Chinese women of different social backgrounds. The educated Chinese are in a quicker process of integration into the Scottish society and have the readiness to accept obstetric technology. The Chinese women's general deference to medical authorities is not an indication of their acceptance of medical intervention but the acceptance of the authority itself, who must know better in the matter. The attitude towards professional authority and the reluctance of accepting medical intervention are relevant aspects of experience for Scottish women too. Therefore the midwifery and medical profession should use its power wisely and be aware of their roles as service advisers. The assumption based on one's own meaning system on the part of the health workers may lead to the development of inadequate policy and poor health status among the

Chinese and the other ethnic groups alike in the UK. Individual and institutional racism are generally the results of this ignorance. The basic maternity services of the future in a wider sense should increase its responsiveness to the needs of different individuals and communities and encourage them to choose and gain increasing control over their own bodies.

Because of certain propaganda, some Chinese women may have too high an expectation of the NHS, little realising its internal problems. It is up to the health workers to be frank with them in various ways. Although this may not be possible, it may be advisable to have older midwives attending to Chinese women's childbirth, which may help to establish midwife's authority over Chinese women's childbearing experiences and to build up women's confidence in childbearing in this country. This approach can redirect Chinese women's deference to medical authorities in some way so that they will not neglect midwives as the main resource of the service.

The study supports the literature that perception and tolerance of pain are culturally oriented and the management of pain can be dealt with differently (§8.2.3, §4.2.4, Schott & Henley 1996: 166). The noisy woman may be coping well, while a quiet woman may not know enough about the available method of pain relief to ask for it. It is also important to remember that Chinese women usually put family loyalties before their own interests and the family members may view they have a major responsibility in taking care of their family members. Therefore opinion and ideas of the family members should sometime be incorporated into the plan of coping with pain and health education should be provided not only to the client but also the family members. By identifying the authoritative family members the health workers can sometime effectively use the influential family member to achieve the therapeutic and supporting goals.

Maternity services in Scotland may consider, if possible, providing more flexible approaches, because it seems there is little recognition of the Chinese women's view which stresses the importance of diet, postnatal rest, and avoidance of the contact with draught, cold water, drinking ice water, washing hair and bathing in obstetric care (§4.3.1, §9.1). The case study done by Eisenbruch (1983) illustrates well what impact a cultural constructed postnatal 'wind illness' may have on a mother.

10.5.2 Education

In a multicultural society it is essential that all health workers are able to understand, respect and meet a diversity of needs. The knowledge of childbearing

practice of other cultures for a health worker can be incorporated into basic midwifery training programmes and the Post-Registration Education and Practice Project (PREP) requirements (UKCC: 2000a) and post basic educational opportunities to enable midwives to provide high standards of care. Time spent will be worthwhile when midwives are practising in a multicultural environment. If the carers do not understand the system used by the client, it would be difficult for them to match their intervention with what is sought by the person experiencing the disease (Eisenbruch 1983: 326). Furthermore, the midwifery and childbearing culture in Scotland can have more to gain than lose in equipping its midwifery professionals with the understanding of childbearing practices of other cultures so they can increase the efficiency of the care they provide and facilitate the women they attend to recover and integrate into host culture.

All Chinese women in the study were voluntary migrants in Scotland, the same can be said about most Chinese in Britain, especially those who came after World War II. This means that, to most of them, settling in Britain was either because of economical, cultural or political reason. The free NHS and maternity service in Scotland are new experiences for them, but their expectation of these services can sometimes turn out to be delusion, especially in maternity care where culture plays a large part. The maternity services have a task of making full use of the positive expectation of these services by the Chinese women migrants. They have to be aware of the differences in the culture of childbearing in order to make the services truly accessible to everyone and to ensure the standards of maternity care are met.

Successful rites of passage provide enough support the help women through their transitional period of childbearing to their motherhood. Some authors (Jordan 1978: 75-78, MacCormack 1982: 18) suggest that the routines of hospital birth may have a potential for helping women achieve a constructive maternal identity in a developed country. In view of the iatrogenic problems imposed by the medicalisation of childbearing, the approach of women centred care might be a good mechanism for women to use the hospital services to their fullest potential.

The maternity service and the NHS in Scotland, as well as elsewhere in the UK, may face an increasing task of providing services across social and cultural boundaries. This challenge can motivate the services to investigate current practices and engage in a reformulation of the medical definition of childbirth in this culture. The dynamics of this challenge are useful for a better understanding of the forces of change in our obstetric practices, which may not necessarily be based on 'scientific' bio-medical evidence but 'the facts of life' generated from socio-cultural reality and the

ideological belief system in time and space. These services have much to gain and to enrich themselves by becoming cross-cultural or international in the process of dealing with the range of various birthing systems.

The research supports the view that the psychological outcome of childbearing and subsequent emotional well-being are closely linked to having information that allows choice and perceived personal control (Green et al 1990: 23). Lack of information are associated with loss of control. The study demonstrates that the information from health professionals was only one of those important information sources for women during childbearing. The information sources and options utilised by the participating women under investigation suggested they were based on personal experience of childbearing, and their concept of the relationship of health and illness. The reliance on personal experience and family network of informal sources of knowledge was evident. This reliance offered some measure of control in the context of an information system. The 'need' for control can also be cultural. Therefore, the aims of any educational programme for health workers in maternity care and childbearing have to address these aspects of multiple intersecting influencing factors and to be geared to such a definition of childbearing.

10.5.3 Management

The NHS has been a great success in term of the achievement of free and comprehensive health care at point of use (Powell 1997: 189). However it fails to live up to the expectation of marginal ethnic groups. It can be argued that the differences in health status and use of maternity services can be translated into unacceptable inequalities to warrant women's demand for appropriate remedial policies and sensitivity to their needs. The needs of different ethnic groups have to be addressed if the requirements of 'Changing Childbirth' (DoH 1993a) are to be met (Schott & Henley 1996: 199).

All health service employers and managers are responsible for ensuring an environment which is safe and supportive for all clients and health workers. They should identify local needs and issues, monitor quality standards of care and redress inequality to provide equal access to services for all who need them (DoH 2000, CRE 1994, Schott & Henley 1996: 199) and equal access to employment (Burchill & Casey 1996: 105-118, Phoenix 1990: 281-2, UKCC 2000b). The consideration of employing a designated health worker within a major general hospital in the urban areas to deal with and provide consultation to a specific ethnic group in health promotion and monitoring childbearing may be feasible practically. This health worker

can relate an individual group's experience and behaviour to a larger social and cultural milieu in which experience and behaviour exist.

To provide culturally sensitive care in line with the principles of the Patient's Charter (DoH 1994, 1995) and Changing Childbirth (DoH 1993a), the experiences and needs of ethnic minority women during their childbearing should be recognised in professional care, so that the health workers can understand why something is wanted and how they meet the needs of different groups of women. The health service managers should be aware of the fact that providing culturally sensitive care demands thought, self awareness (Schott Henley 1996: 204), additional resources in terms of time, flexibility, training the staff at all levels, support and facilities. These needs of marginal women have to be provided in a variety of ways in a multi-ethnic society (Phoenix 1990: 295). Supervisors of midwives (NBS 1995, 1999) have a larger part to play in the process of supporting staff to reflect on the issues of accountability and eradication of racial discrimination in relation to care given to women and working relationship amongst the health workers to work out to achieve and monitor the implementation.

The experiences of Chinese women as migrants, patients and mothers comprise a part of British multi-culture and are portrayed as a miniature of the British medical sub-cultures. The Chinese tend to conform to the dominant culture and change their customs and health seeking behaviour; but in reality, they have difficulties in doing so. Very often they have to lean back on their own cultural origins for comfort and reassurance. The basic maternity services of the future should encourage individuals to gain increasing control over their own bodies and increase their responsiveness to the needs of different individuals and communities.

10.5.4 Future research

The design of this study was to explore different needs and experiences of Chinese and Scottish women having babies in Scotland. Although this was not a quantitative study, the differences and similarities revealed between these two groups of women suggest five areas for future study, spanning action research on practical matters of policy and further qualitative research on the underlying themes.

First, hospital birth happens to remain the first choice for all the women in the study. This may be because most of them were recruited from hospitals, but this may also suggest that their consensus is shared by many others and that their concern with medical safety during childbirth (Jordan 1978: 88) has little to do with childbirth

but the high value the society placed on life in general. However, the Chinese women at the same time showed their preference for self-reliance and a reluctance to use the health services because of difficulty with the English language and other cultural differences. The questions of which mechanisms will facilitate prompt attendance for hospital treatment and how individuals can be helped to acquire attitudes and skills to interact between themselves and with health workers to meet their specific needs remain topics for further research. In this connection, action research on the functioning and effectiveness of bilingual health workers suggested by the Chinese women in the study would be clearly helpful.

Second, food is regarded by the Chinese in general as a therapy and as a preventative measure of illness to promote maternal and baby's good health during childbearing, especially, during postnatal period. When Chinese women are in hospital, they have to confront not only treatments which sometimes conflict with their own perception of 'proper treatment' but also the immediate problems of diet. Since proper diet has taken such an important place in their health, further action research is needed into how hospitals might cater for various dietary habits in a more sensitive way and how diet might come to be seen as part of the care provided by hospital staff.

Third, the psychological and social significance of the postnatal period indicated by the Chinese women in the study deserves further attention. As Asian women in Britain reported in the other studies (Woollett & Dosanjh-Matwala 1990a & 1990b, Henley 1979), Chinese women expressed their concern about their ideologies around the values of postnatal rest, recovery and other prophylactic measurements in avoidance of draught, washing hair, bathing etc. after childbirth. Their views about 'normal' postnatal practices make a sharp contrast with some of the assumptions of the medical model which may therefore serve to exacerbate the potentially stressful nature of childbirth and the transition changes in women's status and their sense of themselves in relation to the other peoples.

Fourth, the diversity of a 'Chinese society' can become even more complicated when the Chinese from different social and cultural backgrounds migrated into different societies and cultures. This study has already partially shown the differences between the Chinese in Scotland from mainland China, Hong Kong and Taiwan areas. They showed different degrees of disintegration and integration of cultures of their origin and of the host country. While I have attempted to illustrate the various cultural meanings of childbearing, a detailed configuration of these multiple discourses remains for further research. Further research on a larger scale can be done to investigate these differences, to provide sociological explanations and

generalisation, and to search for different meanings in childbearing practices that we do not yet understand in order to facilitate the present maternity services to meet the women's needs and increase the efficiency of the care that is provided for them.

Finally, childbearing is cultural and social for different cultural and social groups in Scotland, but at the same time it can become a political issue. Childbearing for ethnic minorities can mean a process of cultural integration. This process may serve at the same time as maintenance of cultural identities. How far a cultural identity is maintained through childbearing and how much is done in cultural integration through childbearing can be further researched among Chinese ethnic minorities, as well as among other ethnic groups in Scotland.

Research on these later three themes demands the kind of in-depth approach utilised in this study — where the researcher obtains detailed knowledge of the women's feelings, experiences and practice to build sufficiently comprehensive picture of the social and cultural context for this to really get inside the complexity, ambiguity and dynamism involved.

This study ends as it started with questions rather than answers. It started from the analysis of differences of childbearing experience in both cultures then moved to the differences that reflect unacceptable inequality in maternity services and finally attempts to offer the potential solutions to some problems that have been posed. The discussion about difference does not mean to preclude equality and the debate about equality does not mean to eliminate difference. These binary oppositions were constructed and deconstructed in this context for the purpose of analyses. Once again the notion of social and cultural construction of childbearing experience has been confirmed by the analysis of differences. A number of the questions raised cannot be fully answered in this single study, but it will have achieved its task if it convinces the reader of the need for the awareness of the differences between peoples and the needs for more theorisation and research as well as changes in practice.

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Appendix I

Topic guide for interview topics of enquiry

Issues	Topics of inquiry			
	Key topics	Pregnancy	Childbirth	Postnatal period
1) Family life & community	Attitude toward having children	Meaning of having children	Different reaction toward a male birth	Different treatment towards boy/girl
	Marriage	Marriage pattern	Birth & marriage	Link between child & marriage
	Women's family & social position	Role in planning, expenditure & domestic duties	Submissive or active role	Influence of sex of the new-born Helpers after birth
	Women as parents	Perception of conception	Ambivalent transition girl to mother	Women, child & partner
	Employment	Time off for antenatal care	Maternity allowance/pay	Dual roles as a mother & employee
2). Health	Health	Attitude towards pregnancy Type of care used	Birth may require some attendance or assistance	A month/a year rest required in these 2 settings
	Conception of Normal, natural/ medical illness	Concept of pregnancy	Concept of birth	Beliefs in confinement
	Precaution	Foetal education	CTG, U/S scan, BP	Rest/mobilisation
	Food issues	Alteration & choice of food for <u>Mother</u> Balanced diet <u>Foetus</u> : Avoidance: alcohol, soft cheese	Low fibre light diet	<u>Maternal</u> balanced diet cosmoically &/or nutritionally <u>Infant</u> diets: breast/bottle feeding
	Mobility & activities	Avoidance: wedding, funeral, cutting, furniture reshuffle in bedroom	Normal daily activity until show/water broke, then room/bed bound	Rest. stay indoor Avoidance: work, sex, & visiting/shopping
	Body image	Changing shape	Loss of privacy & body integrity	Reshaping
	Pollution & cleansing	Women: pollutants Thorough cleaning the room, Personal cleansing	Amniotic fluid, blood, placenta wash/bath	Lochia Shampoo, cold water & bath
3). Institutional birth	Historical perception	Antenatal medicalisation	Conflicts & changes in hospital delivery	Medical dependency
	Health care professionals	Relationship between Dr. & midwife.	Professionals' control of childbirth	Routine information to mothers
	Doctors' model	Knowers	Those who perform assisted deliveries	Supervisors
	Midwives' model	Healers, educators	'pushing organiser'	Educators
	Women as patients	negotiators & recipient	Labourer & delivering	Role of mothering -- provider & carer
	Pain management	Pharmaceutical or psychological	Activity vs. passivity	Radical or conservative
	Racism/ classism	Institutional antenatal care	Dominant medical approach	Demands of different classes, Under-utilisation of service

Appendix II

Protocol for 'A comparative study of childbearing of Chinese and Scottish women'

Aims of the study

To compare the childbearing experiences of Chinese and Scottish women in Scotland in order to help midwifery and medical staff understand the different needs of these two groups of women to improve the understanding of women's childbearing experiences and to facilitate choices of care, place of care, continuity of care and the right to control over their own bodies.

Method

A two-case study approach is employed to deal with this variety of information-- documents, interviews and participant and non-participant observations.

The study involves:

- 1) Participant and nonparticipant observation of some deliveries in labour ward.
- 2) Access to booking clinic to antenatal booking clinic/ward to identify and meet women.
- 3) Four interviews with 10 Scottish and 10 Chinese women at antenatal, postnatal wards and/or at women's home respectively. The women will be asked about their experience of childbearing, childbirth and their attitude toward obstetric technology and the relationships between childbirth, illness, food, medicine and cultural influence.
- 4) An interview with one consultant, two senior house officers and two house officers/medical students
- 5) To talk to one midwife manager, one senior midwife, one rural community midwife, a junior midwives and a health visitor.
- 6) To talk to one senior and one junior dieticians and one kitchen manager
- 7) To talk to one maternity senior and one junior physiotherapists.
- 8) Interview 5 women's partners selected at random.

Definition of subject

Two controlled groups of women will be recruited and interviewed. The Scottish women will be those at least whose parents were born in Scotland and the Chinese women are the first or second generation immigrants from mainland China, Hong Kong and Taiwan. The Scottish women will be matching with the Chinese group by age, parity and social class.

Length & contents of interview

The interview will approximately last 45 minutes to an hour. The interview will be tape recorded with the subject's consent. Semi-structured interview guide-line with the following topics:

- 1) experience of birth
- 2) attitude towards technology

Analysis

The analysis of the study will be done by means of a well established qualitative methodological strategy.

Result

The woman and the hospitals involved will be offered a form of summary at the end of investigation

Appendix III

Patient information sheet

**The Faculty of Social Sciences
University of Edinburgh
18 Buccleuch Place
Edinburgh**

Tel: 536 7266/650 3985

1/1/1995

Dear Madam,

I would be very grateful for your help.

The study carried out at present is a comparative study of childbearing experiences of Scottish and Chinese women. I am interested in your experience and your view of childbearing and childbirth. This information will be used as part of a PhD thesis based in the Faculty of Social Sciences, the University of Edinburgh.

Your name has been drawn randomly from a list of pregnant women booked at antenatal clinics. If you agree to take part in this study, I would interview you with your permission, during pregnancy, before and after your childbirth.

Your experience will be very helpful to the improvement of future maternity care to meet the different needs of yours during the pregnancy, labour and post labour and to facilitate choices of care, place of care, continuity of care and the right to control over their own bodies and birth.

All information given are strictly confidential and used only in conjunction with this study. You are, of course under no obligation to participate. Please feel free to say no, or withdraw at any time during the study and this does not affect the care or treatment you receive. If you have any question about this study, I can be contacted at the above address and phone number.

Your participation and support of this study will be very much appreciated. Many thanks again.

Yours sincerely

Ngai Fen Cheung
Research midwife

Appendix IV

An information sheet for professionals

**Faculty of Social Sciences
University of Edinburgh
18 Buccleuch Place
Edinburgh**

Tel: 536 7266/650 3985

1/1/1995

Dear Sir/Madam,

I would be very grateful for your help.

The study carried out at present is a comparative study of childbearing experiences of Chinese and Scottish women. This study will be used as part of a PhD thesis based in Faculty of Social Sciences, the University of Edinburgh.

The aim of this study are to improve the understanding of women's childbearing experiences, to provide useful insights as to how present maternity practices might be improved for the women having babies in Scotland.

It will be very helpful to listen to that your ideas of the needs of the women/ care in pregnancy, normal or natural childbirth / birth management/ the patients' diet, that will be very much appreciated for the future better maternity care.

All information given are strictly confidential and used only in conjunction with this study. You are, of course under no obligation to participate. Please feel free to say no, or withdraw at any time during the study. If you have any question about this study, I can be contacted at the above address and phone number.

Your participation and support of this study will be very much appreciated. Many thanks again.

Yours sincerely

Ngai Fen Cheung

Appendix V

Consent form

Title of the proposed research
A Comparative Study of Childbearing of Chinese and Scottish Women

Name of investigator:
Ngai Fen Cheung

Address
Faculty of Social Sciences
University of Edinburgh
18 Buccleuch Place
Edinburgh
Tel: 536 7266/650 3985

Further information is available from
Dr Rosemary Mander
Nursing Studies
University of Edinburgh
Adam Ferguson Building
George Square
Edinburgh
Tel: 650 3896

- * I agree to participate in this study.
- * I have read this consent form and Patient Information Sheet and had the opportunity to ask questions about them.
- * I agree for notice to be sent to my General Practitioner about my participation in this study.
- * I understand that I am under no obligation to take part in this study and that a decision not to participate will not alter the treatment that the patient would normally receive.
- * I understand that I have the right to withdraw from this study at any stage and that to do so will not affect my treatment.
- * I understand that this is non-therapeutic research from which I cannot expect to derive any benefit.

Signature of patient: _____

Signature of investigator: _____

Date:

Appendix VI. Interview schedule

Interview schedule 1: Pregnancy

Aims: (1) to introduce myself and establish a rapport, (2) to get some basic background information about family life, gender and health and (3) to find out about the pregnancy

1.1 General background

Age, parity, occupation (self & partner), religion, number of children, & length of stay in Scotland.

1.2. Pregnancy precautions

1.2.1. Food

Maternal

Have you changed your diet since pregnancy? How? And why?

What food do you eat when you have morning sickness?

What are your cravings? How do you choose your food? Why?

What diet did you choose to be on at home during pregnancy?

How did you decide your choice of diet/food? Why?

What foods are good for pregnant women? Why? What bad?

foetal

What food do you have to avoid for your baby in pregnancy?

What food do you take simply for the benefit of the foetus only?

1.2.2. Mobility & activities

What kind of physical activity, if any do you have to avoid during pregnancy?

What exercises/activity do you take? Where can you go or not go? Why?

Do you often go to the places as you did in the past? If not, why not?

How do you feel about moving house if you had to during pregnancy?

What measure do you take to protect your baby? Are you taking any... (prompt & explore)?

1.2.3. Pollution & cleansing

Do you feel unclean when you are pregnant? Why/why not?

Do other people also see a pregnant women as 'unclean'?

Do you have to be separated from the rest of your family? If yes, for how long? Why?

When do you normally cleanse your house or yourself? Why?

1.2.4. External health care and assistance

What health care practitioner do you or your family go to when you are ill? How often?

Do you attend any self-help group? Where can you get family advice?

Have you used any other health practitioners?

What measure do you routinely take yourself to prevent or treat illness?

What care do you feel you need from hospital during pregnancy?

What type of care do you feel you need in your pregnancy? From whom (Husband, wider family, hospital or GP)?

1.3. Household background

1.3.1. Family

How many people are there in your household?

How long did you know your partner? How did you meet him? How do you feel about him?

What does your partner do for living?

Do you have other relatives locally?

1.3.2. Employment

What is your job? Can you get time off if you want to?

Can you retain your present job if you want to?

Would you like to go back to your work after having this baby?

How long can you get paid maternity leave?

What state or other maternity benefit you are entitled to?

1.3.3. Having a child

How did you feel on discovering that you are pregnant?

How did you feel about your body changes?

Do you know how babies are conceived? Was the pregnancy planned?

Whose idea was it to have a child?

What do you want / expect from having children?

What does having a child mean to you personally, your family and your community

How many children do you hope to have?

1.3.4. Sex of baby

What would you like to have, a boy or a girl? Why?

Are you interested in knowing your baby's sex before its birth? Why?

Will you be treated differently by your family if you have a boy /girl? Why?

Will the child be treated differently?

Interview schedule 1: Pregnancy

产前第一次采访

I. 一般情况

年令, 职业, 信仰, 孩子, 家庭人口, 旅居年限。

1. 家庭

你家里有几口人?

什么时候结婚?

你怎样认识你先生的? 认识多长时间了? 感情如何?

他做什么工作?

2. 孩子

生孩子对你有什么含义?

怀孕后你感觉如何? 是否是计划中的孩子?

是谁想要这孩子?

为什么要这孩子?

有了这孩子对家庭, 社会有什么影响?

你计划要几个孩子?

3. 孩子性别

你想要男孩还是女孩子?

在生产前你是否想知道孩子的性别?

生男孩或女孩子, 家里人对你是否有不同?

4. 医药

你私家医生是谁?

你是否使用民间疗法或者其他相象的医疗网?

你通常是如何预防和治疗疾病?

什么时后你觉得你需要到医院去看病?

II. 孕期保健

1. 食品

孕期你是否需要重新调整自己的饮食?

在有妊娠呕吐后, 你通常吃什么食物?

孕期一般需要吃什么?

你是怎样或根据什么选择你的食物?

什么食品对孕妇有益？

为了胎儿的健康什么食品需要忌口？

为了胎儿的健康你得吃什么东西？

2. 活动

在孕期间什么东西不该做？

在孕期间你锻炼吗？

怀孕后你觉得你的体形如何？

你是否和以往一样出去窜门？如果不去，是什么原因？

你觉得孕期搬家如何？

你有什么措施来保护胎儿？

3. 清洁和污染？

孕妇是否脏？怀孕后你是否觉得自己脏？

怀孕后是否得和家人或其他人分开？

如果分开，得分开多长时间？

什么地方孕妇不能去？

4. 职业

你做什么工作？

你是否能获薪假去做产前检查和保健？

生孩子后，如果你想回去工作，你是否能保持原职？

带薪产假有多长时间？

产后你是否还想回去做原来的工作？

5. 社区护理

产期你需要什么样的保健护理？

从哪里？你丈夫，亲属或私人医生？

除了看西医，你还看中医或其他的一些医务人员？

你去了没有去产前班？你觉得它们怎样？

孕期为了孩子的健康，你是否得改变自己以往的生活习惯？

Interview schedule 2: Antenatal care & plan for pregnancy

Aims: To find out what they know and how they feel about (1) various aspects of the antenatal care, (2) birthing plan and childbirth.

2.1. Antenatal care

2.1.1. Antenatal care

What antenatal care are you receiving?

How often do you attend antenatal care? Is it too much or too little?

Do you like to attend them?

What antenatal care do you prefer hospital, GP surgery, midwife or the care offered by the family members? –

2.1.2. Use of technology

Have you got explanation about the abdo-examinations/ blood/ urine/ AFP/ CTG/ultra-sound scan or other tests?

How do you feel about them?

2.1.3. Interaction with health professions (GP, midwives, hospital doctors)

What is the difference between doctors' antenatal care and that of the midwives?

Do you feel you get the same care as the other patients?

2.1.4. Antenatal classes

Have you ever attended any antenatal classes?

How often do you attend antenatal classes? How do you find them?

Which one is more helpful to you? In what way? Safety? Discomfort? Intensive?

What useful techniques have you learnt to prepare for the birth?

Do you hope to use them?

2.2. Plans for the birth

2.2.1. View about childbirth

How do you see childbirth: as an illness or a natural reproduction process?

What does a 'normal' or a 'natural' childbirth mean to you?

What do you have to do in order to have one?

2.2.2. Place of birth

Where do you feel is the best place for you to have your baby?

How do you feel about going into a hospital to have your baby delivered?

When did you book a hospital/ home/ DOMINO delivery?

2.2.3. Present at birth

Who do you want to be present during the birth?

2.2.4. Position of birth

Do you have any views on the way your baby is delivered?

What is your preference? Why?

What position of delivery do you hope to use?

2.2.5. Pain relief

What pain relief do you expect to use in labour?

Do you think you need breathing exercises/ relaxation technique/ distraction tactics/ analgesia/ TENS/ entonox or epidural to cope with labour?

Are you happy to take them if you feel you need pain relief?

2.2.6. Birth plan

Do you have a birth plan? What is it?

Why have you made the choice you have? Fear? Anticipation?

Who helped you to draw it up?

Do you feel you have the information you need in order to decide on what you want?

What, if any, changes could be made to the antenatal care services to improve your experience of pregnancy?

Interview schedule 2: Antenatal care and plan for pregnancy

产前二

I.

1. 产前护理

你了解到有什么产前护理？

你觉得它们怎样？太少还是太多？

你喜欢去吗？经常去吗？

如果有选择的话，你愿要那种产前护理，家庭式或医院的？

2. 和医务人员的来往

你得到什么样的产前保健护理？

医生和助产士的产前检查，保健有什么不同？

哪种方式较好？

你觉得你是否能和其他人一样得到同等待遇？

3. 检查技术的运用

你觉得医院孕期胎心电图检查如何？

腹部胎位，胎心音检查或血液，尿液检查，胎儿甲形蛋白检查或其他检查？

4. 产前教育

你是否去过产前教育课？

你经常去吗？你的对象去吗？

你觉得它们怎样？

哪些内容对你最有用？

你学到了什么有用的技巧？

你觉得它们怎样？你准备用它们吗？

II. 分娩计划

1. 对生孩子的看法

你认为生孩子是一个人类自然生育的过程还是疾病？

你认为什么样的分娩是自然分娩？

生孩子到底是怎么回事？

Chinese version of Interview Schedule

2. 分娩地点

在哪生孩子最好？

你觉得到以医院生孩子怎样？

你什么时候到医院预约床位？是怎样预约？

你准备要医生还是助产士接生？

3. 陪生

你愿意要谁陪你在产房？

4. 分娩姿势

你是否知道你能选择你的分娩姿势？

你喜欢什么样的分娩姿势？

你准备用什么样的位置来生你的孩子？

5. 去痛药

你觉得你得用去痛药吗？

如果你觉得你需要用去痛药，你愿意用它们吗？

你准备用什么去痛药？

6. 分娩计划

你是否有分娩计划？是什么样的计划？

谁帮助你订的计划？

你的助产士是否和你一起讨论你的计划？

你是否觉得你已有充分的信息去作出自己的选择？

为什么你选择你所选择的办法？

Interview Schedule 3: The birth

Aims: To get the women to describe (1) what happened at each stage of labour, and (2) how they felt about it all
What kind of birth did you have? How is your birth?

3.1. What happened in the first stage of labour?

a). Use of monitoring technology

Did you have CTG monitoring?

How often did your midwife monitor your foetal heart rate?

Did she explain her findings to you? Did you understand them?

b). Use of intervention technology

Did you have ARM/induction /augmentation /epidural/ episiotomy /forceps / caesarean section/ IV infusion/ IV syntocinon?

c). Pain relief technology

What pain relief methods did you use? Who advised you?

Which method worked the best for you?

Are you happy to use pain relief, if you feel you need it?

d). Presence of partner or other people?

Who was present?

Did you enjoy having someone close to you present at birth?

What can the other family member do for you, when a long labour occurs?

e). Food

What, if any, drinks or food did you take in the early stage of labour? Why?

3.2. What happened in the second stage of labour?

a). Women's perception of second stage of labour

How did you know that your labour was progressing?

b). Birthing position

What position did you deliver your baby in?

How do you feel about the position?

c). Monitoring technology of pushing organisation

Did you feel that you needed instruction to push your baby out?

How did you find the midwife's guidance on pushing?

Were you able to do what the midwife asked you to do?

d). Intervention technology

Did you have an episiotomy/ section/ forceps?

Did you have any explanation about why you need an episiotomy/ section/ forceps?

Did the local infiltration help with the pain during cutting?

How did you feel about them?

3.3. What happen in the 3rd stage?

Did you have any difficulty in delivering the placenta?

Do you have any syntometrine injection?

What do you think about having syntometrine to assist placenta delivery?

Do you think you can deliver placenta without syntometrine?

How do you feel about the midwife pulling the cord of you placenta & deliver it?

3.4. How do you feel now

a). About the birth plan

Was your birth plan is useful?

Was there further information you now feel you needed before hand?

Have your opinions changed about any of the choices you made?

b). About birth in general

Do you feel your birth was normal/ natural?

How do you feel about the way your childbirth is managed?

How was baby dealt with by medical staff? (weighting, measuring, bonding, etc.)

What was the difference between the midwives' role and the doctors'?

Did you feel you get the same care as the other mothers?

What, if any, changes could be made to the maternity services to improve your experience of the labour and birth?

Interview schedule 3: The birth

分娩

I. 第一产程

1. 观察技术

胎儿是否用心电图来观察？观察频率如何？

助产士是否和你解释检查结果？

你能否理解她的解释？

2. 人工干涉技术

你是否接受了人工破膜，人工引产，人工催产，脊椎，脊膜麻醉，会阴切开术，产钳，静脉输液，静脉点滴催产素？

3. 去痛技术

你使用了什么样的去痛方法？谁建议你用的？

什么去痛方法对你最有效？如何有效？

4. 陪生

在你生孩子的时候，你是否喜欢让你的亲属在场？

当难产发生后，你能做些什么？

其它家庭成员能为你做些什么？

5. 食物

如果你觉得饿的话，在第一产程期间，你是否能吃或喝东西？

吃什么？喝什么？

II. 第二产程

1. 过渡时期

你是怎样知道你进入第二产程？

2. 分娩姿势

你选择什么样的姿势来生你的孩子？

你用什么姿势来生你的孩子？

你觉得你选择的位置或姿势如何？

3. 人工控制观察技术的运用

你是否需要引导来往下憋？

Chinese version of Interview Schedule

你觉得助产士的往下憋的引导如何？
你是否能做到她所叫你去做的？

4. 会阴切开

在生孩子的时后，你的会阴是否被切开？
她们是否对你的解释了为什么得切开？
在切开的时候，局部麻醉是否能减轻疼痛？
胎儿脐带绕颈是什么意思？
胎儿在胎膜破水前生出是什么意思？
孩子生下后你觉得如何？

III. 第三产程

在胎盘分娩中你是否有困难？
你是否用了Syntometrine？
你觉得用这种药怎样？
你认为你是否可以不用药而自己分娩胎盘？
你觉得助产士的胎盘牵引术如何？
你认为孩子是否需要注射维生素K注射液？

IV. 自身感觉

1. 婴儿

生了个男 或女孩感觉如何？
生男孩或生女孩家里人是否对你一样？

2. 分娩计划

你的分娩计划是否有用？
你是否改变了你以前的看法和选择？
你觉得你还需要什么样的信息？

3. 分娩概论

总而言之，你觉得你这次分娩生产如何？

4. 对医务人员的看法

接受了人工破膜，人工引产，人工催产，脊椎，脊膜麻醉，
会阴切开术，产钳，静脉输液，静脉点滴催产素
Syntimetrine，内科或外科分娩，你感受如何？

Interview schedule 4: Postnatal care

Aims: To discuss the issues of the postnatal care, the rest, diet, cleansing, mobility, activities and general experience of whole childbearing, childbirth and childbearing

4.1. Postnatal care

4.1.1. After pain

Did you have after pain? How severe?

What method or drugs did you use to relieve after pain?

How do you feel about them?

4.1.2. Baby blues

Did you feel down after having your baby? How? /When?

4.1.3. Postnatal routine check-ups

How do you find postnatal check-ups/ domiciliary visits for both yourself and the baby?

4.1.4. Post birth experience

Have you come across any difficulty when you seek medical treatment?

What did you feel was most difficult to cope with while in hospital? (Privacy/ routine/food/bathing/child bonding?)

What did you expect from hospital? How did you feel about the staff?

When do you think you need hospital professional help/ treatment?

Do you feel you could get the same care as the other mothers?

4.2. Postnatal activities and diet?

a). Maternal

4.2.1. Mobility and activities

How long did you have to remain indoors?

When did you start to go out and do your own shopping? Why?

When do you think you can have your first bath? Your first shampoo? Why?

When could you meet your relative and friends after birth?

When did you start to visit your friend? Why?

When can you resume your (sex) relationship with your partner?

4.2.2. Diet therapy

What foods are good for you during your postnatal period? Why?

How do you choose your food?

Who chooses the food for you?

What should women normally eat during postnatal period?

How do you prepare your food? Who prepares it?

Did you eat with the rest of the family together or separately?

b). Neonatal

4.2.3. Naming the baby

Who names the baby? Why?

4.2.4. Sex of the baby

How do you feel about having a boy/girl?

Does the sex of the baby has any effect on the care you received from your family?

4.2.5. Baby feeding

Are you breast feeding or bottle feeding your baby? Why?

What problems, if any, do you have with breast/ bottle feeding?

What milk/ food do you use for the baby? Why?

4.2.6. Baby care

When do you bath your baby, if he or she was born at home? Who does the first bath?

What kind of water do you use to bath your baby? Boiled or herbal water? Why?

What problems do you have in the care of your baby? Why?

When do you announce his/ her birth to your relative/ friends?

When do you think your baby needs religious services, e.g. baptism, naming etc.?

Do you think you are well prepared for the care of your baby?

How long does it take you to be comfortable with caring for your baby on your own?

4.3. Conclusion

How do you feel about having a baby now that it is born?

Does having this child change your relations with your friends and family?

What, if any, changes do you think could be made to the postnatal care service to improve your experience of the first few weeks and months after the birth?

Interview schedule 4: Postnatal care

产后护理和活动

I. 产后护理

1. 产后疼痛

你用什么方法和药物去克服产后疼痛？

你觉得它们怎样？

2. 产后忧郁

你觉得产后忧郁是怎么回事？自然现象还是疾病？

3. 产后常规检查

你觉得产后常规检查对母子或母女有什么作用？

4. 你感觉如何？

看病你有什么困难？

在医院你觉得什么最难对付？

你希望医院能为你做些什么？你觉得医务人员如何？

医院对你如何？是否有不同的待遇？

什么时候你觉得你得去医院？

你觉得你是否能和他人一样得到同等的待遇？

II. 产后活动和饮食

母亲

1. 你得在室内休息多长时间？

什么时候你能上街买东西？为什么？

什么时候你能洗第一次澡？洗头发？

产后什么时候你能会见亲戚朋友？

什么时候你能走访亲友？为什么？

什么时候你能和对象同房？

2. 饮食疗法

什么样的食物对产妇有益？为什么？

你是如何选择自己的食品？

谁替你选择你的食品？

产后你通常吃什么？

Chinese version of Interview Schedule

你是如何准备和煮你的食品？谁煮给你吃？

3. 给孩子起名

是谁给你小孩起名？为什么？

4. 小孩性别

小孩的性别是否会影响到家人对你的照顾？

5. 婴儿哺育

你准备自己哺育还是用牛奶喂孩子？为什么？

人工喂养或自己哺养有什么困难？

你用什么奶，食品喂孩子？为什么？

喂男孩和女孩是否一样？

6. 婴儿护理

假如孩子在家生，什么时候你给孩子洗澡？

谁给他或她洗澡？

用什么水给孩子洗？温开水或是草药水？为什么？

在婴儿护理中你有什么具体困难或问题？

什么时候给孩子过生日？

什么时候对亲友宣布他或她的生日？

什么时候你认为孩子应进行宗教礼仪，例如：洗礼，起名等？

要多长时间你才能独立照顾自己的孩子？

Appendix VII

Copy of ethical approval



1702/95/6/7

Mr Les Malone

Dear N F Cheung,

REQUEST FOR ETHICAL APPROVAL - "A Comparative Study of childbearing of Chinese and Scottish Women."

Thank you for submitting the above protocol for ethical approval. The Paediatrics & Reproductive Medicine Research Ethics Sub-Committee has considered this protocol and has granted ethical approval.

Under the terms of the Scottish Office Home and Health Department Guidelines on Local Research Ethics Committees this decision has been notified to the NHS body under the auspices of which the research is intended to take place. It is that NHS body which has the responsibility of deciding whether or not the research should go ahead taking account of the advice of the Research Ethics Sub-Committee.

A condition of this approval is that you are required to notify the Sub-Committee, in advance, of any significant proposed deviation from the original protocol. Reports to the Sub-Committee are also required once the research is underway if there are any unusual or unexpected results which raise questions about the safety of the research.

In addition, researchers are required to report on success, or difficulties, in recruiting subjects in order to provide useful feedback on perceptions of the project among patients and volunteers.

Yours sincerely,

Mr Les Malone
Secretary
Paediatrics & Reproductive Medicine
Research Ethics Sub-Committee

Appendix VIII: Chinese glossary

Chinese glossary

<i>Beijing</i> 北京	the capital of China
<i>biao-li</i> 表里	exterior and interior
<i>bu</i> 补	strengthening one's health
<i>bupin</i> 补品	food and herbs good for health
<i>buyao</i> 补药	herbs or medicine as good for health
<i>chongxi</i> 冲喜	bring bad luck to brides
<i>chop suey</i> 杂水菜	a dish with mixed meats and vegetables
<i>danggui</i> 当归	Chinese angelica a plant on the border between food and medicine for women in childbearing
<i>dangshen</i> 党参	codonopsis pilosula a plant on the border between food and medicine for women in childbearing
<i>feng</i> 风	wind
<i>fouchen</i> 腑肠	surface and deep-down
<i>Fujian</i> 福建	a province name in China
<i>gan</i> 干	dry
<i>Guangdong</i> 广东	a province name in China
<i>Guangxi</i> 广西	a province name in China
<i>guiyuan</i> 桂圆	dry longan
<i>Guomindang</i> 国民党	National Party in Taiwan
<i>han</i> 寒	cold
<i>han</i> 汗	perspiration
<i>Han</i> 汉族	an ethnic group in China
<i>hanre</i> 寒热	chills and fever
<i>Hakka or Kejia hua</i> 客家话	a dialect in Southern China
<i>huajuan</i> 花卷	steamed twisted roll
<i>jaozi</i> 饺子	dumplings
<i>jiazi</i> 甲子	a cycle of sixty years
<i>laobing</i> 烙饼	pancake
<i>leng/ han</i> 冷寒	cold
<i>mantou</i> 馒头	steamed bun
<i>Manzhou (Qing) dynasty</i> 满洲或清朝	<i>Qing</i> dynasty (1616-1911) is a dynasty of the Manzhou conquerors, who were considered aliens. Most Chinese consider that the history of <i>Qing</i> dynasty is the history of shame to <i>Han</i> people (Dikotter 1992:25), because they perceived themselves as the descendants of <i>Han</i> not <i>Manzhou</i> .. The <i>Qing</i> dynasty was defeated in the Opium War by the West. The history of <i>Qing</i> dynasty is conceived a national shame.
<i>Ming dynasty</i> 明朝	<i>Ming</i> dynasty (1368-1644)
<i>nuomi tianju</i> 糯米甜酒	glutinous rice wine
<i>qi</i> 气	live force
<i>qicheng bao</i> 七成饱	eating 70 percent full — meaning not to have too much
<i>Qing dynasty</i> 清朝	See <i>Manzhou</i> dynasty
<i>qifeng</i> 脐风	'cord wind' means umbilical tetanus
<i>qufeng</i> 去风	dispelling the 'wind' syndrome

Appendix VIII: Chinese glossary

quyu huoxue 去瘀活血	removing blood stasis and promoting blood circulation which is often achieved through diet therapy combined with administration of the Chinese herbs.
re 热	hot
ren mai 任脉	a channel to control women reproductive system
sancong 三从	‘three obediences’ prescribed in the doctrines of ancient Chinese literati represented by the literary and cultural figure Confucius: obedience to father before marriage, to husband after marriage, and to son after the death of husband. ‘three dependencies’: the logic for the dependencies was that before daughters got married, their father had to support them; after their marriage their husband had to do that; and in their widowhood, their son had to bear the responsibility.
shenghuatang 生化汤	a set prescription of Chinese medicine. It has Chinese angelica 当归, motherwort 益母草 (leonurus heterophyllus), safflower 红花, dangshen 党参 (codonopsis pilosula), huangqi 黄芪 (the root of membranous milk vetch/ astragalus membranaceus) etc., and contains herbs of ergometrine. The number and the amount of herbs are prescribed according to the woman’s physical and psychological condition.
shi 湿	wet
shi 实	stuffy
Song dynasty 宋朝	Song dynasty (960-1279)
taidu 胎毒	womb poison
taijiao 胎教	fetal education
taishen (tsi shen, thai-sin) 胎神	goddess who was believed to protect the child and remained attached to the child’s body until about four months after birth
Taiwan 台湾	an island off the SE coast of China
tu 吐	emesis or gastric aspiration
xie 泻	diuresis and bowel evacuation
xifu 媳妇	daughter-in-law
xu 虚	weak
xu-shi 虚实	weak and stuffy
yang 阳	meant ‘sunny’, is associated with heat, summer and symbolises masculinity and positivity
yang xu 阳虚	weak from outside
yin 阴	originally meant ‘shady’; it is associated with the phenomenon of cold, winter, cloudy, rainy, darkness; and symbolises femininity and negativity
yin xu 阴虚	weak from inside
yuan 元	a Chinese dollar
zuo manyue 坐满月	‘doing the full month’ — a celebration given to the new-born when he or she is a month old and safe and sound

Appendix VIII: Chinese glossary

<i>zuo xiao yue</i> 坐小月	This is a newly developed practice to sit in for a month not directly after a childbirth but after an intended termination of pregnancy (TOP). Because <i>zuo xiao yue</i> is not directed after a childbirth but a TOP, this month is considered smaller but it does not imply any less importance. This practice was reported by four of the Chinese women in my study from mainland China (W4, W8, F1 & F6). It is thought to be created by the women with 'wind' syndrome with a hope to have their diseases cured. Usually the women were entitled to have two-week recovery leave by law after a TOP, then they had to request another two weeks sick leave to 'sit in for the small month'. They used this opportunity to follow rigorously all the postnatal rules and restrictions they could in order to cure those postnatal conditions.
<i>zuo yuezi</i> 坐月子	sitting in for the month postnatally

Appendix IX

The background of the women respondents

Twelve Chinese and ten Scottish women were contacted and two of the Chinese withdrew from the study. In order to preserve them anonymous Chinese women were coded with numeral numbers and Scottish women, alphabetic letters.

W1

W1 is married to a self-employed Chinese take away shop proprietor. Her husband migrated to the UK 15 years ago with his family from Vietnam. W1 only came to Britain three years ago from a small town in Guangxi, China. Both of them are Cantonese speakers, but they use Hakka between themselves. She speaks little English and her husband spoke and answered many questions for her. He appeared to be the dominant figure in the family.

W1 had experienced a normal pregnancy, but her baby was born by Ventouse extraction following fetal distress. The baby had to be hospitalised for another two days after her discharge for photo-therapy because of neonatal jaundice. The most difficult things W1 had found about living in Britain were language and food. There were not enough fresh vegetables and fruit available in the market here. The supply of most of the meat and fish were frozen. They regretted the unavailability of some 'hot' and 'cold' herbs and food and endeavoured to find substitutes.

At the end of this interview the couple said they would be quite happy to have some future return visit from me. However, all subsequent attempts to arrange a follow up interview were thwarted. First she said over the phone that she had to visit her friends and relatives in Edinburgh because that week was the first week after her *zuo yuezi*. Later the phone was picked up but no one answered the phone. When she was contacted again about three months later - the third time-, her phone number no longer existed. It seemed likely that they were feeling insecure. A month later their shop was closed and their flat was on the market for sale.

W2

W2 was first visited when she was three months pregnant with her first child. Both her husband and she had come from Taiwan in October, 1993. Her husband was doing a PhD at the University of Edinburgh. Originally she had planned to study economics but had to abandon this idea when she discovered that she was pregnant. She was quite disappointed by this.

She appeared rather depressed. She thought that a study of the different experiences and needs of Chinese women was not much use, that it could not change the present system as it had been existing for such a long time. She expressed her regret that she could not take part in the study because of the objection from her husband.

She was quite happy with the maternity care she received. She expressed her gratitude toward the NHS for the free and equal treatment even though she was a newly arrived foreigner. She did not think that she could ask for anything more than that. At the same time she expressed confusion about conflicting medical advice between the medical staff here and her traditional belief and practices at home. For instance, pig liver is believed to be rich in vitamin A and D and very good for blood building during pregnancy in Taiwan but it is considered as harmful for the fetus in Britain; she was advised here to have plenty of tomatoes but at home tomato was thought to be too cold for pregnant women.

W3

W3 came to Edinburgh from Taiwan in 1992 to do her postgraduate study and married a Scot a year after. The couple started a travel agency business in a busy city commercial centre after their marriage. They worked hard and their business appeared to be doing reasonably well.

W3 was 24 weeks pregnant when she was first visited. She had a healthy pregnancy and managed to work full time until 34 weeks gestations and then part-time till her childbirth. She had a drug free, straight forward delivery and gave birth to her first ten pound baby girl. Throughout all the interviews she appeared relaxed and frank, and knowledgeable about traditional customs and beliefs.

One of the most interesting points she raised was that childbirth was viewed as a social business in Scotland but it was considered a private business in the eye of a Chinese; in a more a narrow sense, a woman's business. This was especially true in Taiwan.

She was surprised to find out the different practices between people here and those in Taiwan during the late antenatal period and postnatal recovery in the first month after birth. She was ready to follow these two different cultural practices according to different situations in order not to upset her mother and mother-in-law. When she visited her mother-in-law's family she would eat anything that was offered even in the knowledge that she was not allowed to have it according to Chinese culture.

W3's parents came from Taiwan before child's birth and stayed to help her while she was sitting in for the month and she followed Chinese custom of *zuoyuezi*, after the childbirth as her own mother was in Edinburgh. She had confidence and belief in Chinese food therapy for childbearing but kept some reservation for the restriction on Chinese cultural specificity such as needle work, cutting, nailing during pregnancy. She did have a proper *zuo yuezi* and went back to work full time soon after she found a child minder.

Her selective approach towards two different cultural practices according to her understanding and needs is quite common among well educated Chinese women.

W4

W4 claimed to marry her undergraduate tutor ten years ago. She came from Holland where she was doing her PhD, to join her husband in Edinburgh when she was pregnant. Her husband had got three years contract research work in Edinburgh. They are both originally from Cheng-du, Sichuan, China.

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She had hyperemesis and ended up with dehydration in her early stage of pregnancy. After two weeks hospital treatment her pregnancy progressed smoothly. She had a 6 pound 36 weeks preterm girl after a medical delivery. She stayed in hospital with her baby for ten days because of prolonged neonatal jaundice.

She was first interviewed when she was 32 weeks pregnant and followed up until twelve months after the birth. Four interviews and two social visits were made. She was not interested in finding out about Chinese customs and practice on childbirth and antenatal care through reading or oral story telling of people. Equally she did not appear keen to know why her blood was taken each time when

she attended her antenatal check-ups. She had more confidence in her husband and the medical professionals than in herself. This was demonstrated well in her reaction to the treatment she received during her visits to her GP and her stay in hospital while she was having her baby (Ch 8, 9).

She stated frankly that her husband was the centre of everything in the family. She always behaved like a child in front of him and he appeared to have some sort of authority over her. That might be able to explain why he acted as her spokesman during her interactions with the medical professionals. She appeared to enjoy and tries to maintain this relationship by keeping herself in the background, even though she studied Chinese women's social position, social power structure and domestic decision making. Their relationship appeared to be rather unstable before the pregnancy, due to unequal position and the long time living apart, and post birth due to the interference from her mother-in-law. W4 blamed cultural environmental changes for the emotional ups and downs of their intra-family relationships. The over-protective approach by her husband prevented her from finding out answers for herself in her life and deskilled her in her social contacts with others to some extent, possibly due to the early loss of her own parents.

Her mother-in-law took over child caring after W4 was discharged from the hospital. She made the decision to add bottle milk during the night and completely bottle fed the baby a month later. She became the boss of this young family, bossing her son around and telling her daughter-in-law what to do and how to behave. The emotional state of W4 changed a lot following her mother-in-law's arrival in subsequent interviews and meetings -- she was less lively and more hesitant.

Her mother-in-law made a distinction between urban and rural people, telling me that urban people were thought to be more open minded and they did not mind whether they had a boy or a girl but rural people did. Her preference for a boy was repeatedly expressed reluctantly and timidly in order to say it in an acceptable adult way. Four months after the birth, W4 changed her religion from Buddhism to Christianity because she thought Christianity was more scientific and appealing.

W5

W5 had come to Britain eight years ago from Taiwan and had married a Scottish draftsman three years ago. She had a responsible job. She lived in a three apartment flat in the centre of the city and six months after her first baby boy was born she moved into a new house. Three interviews took place at her home and the last one, while having a walk around the university ground with the baby sleeping in the pram.

W5 had a sign of threatened miscarriage at about two months into the pregnancy. Everything went on smoothly with close medical supervision. She delivered her full term baby under epidural because she was greatly influenced by her husband's view on pain relief. He thought 'if someone had a good labour, epidural certainly would not have any influence on it. If someone had a poor labour, epidural would help her'.

Although W5 was knowledgeable about the traditional customs, practice and restrictions related to childbearing and childbirth, she was very selective to what she should or should not do during that period of time. She also expressed strong views about the NHS antenatal classes which she felt were not as good as they were supposed to be.

She gave quite a lot of thought to racial problems. Her approach towards them was interesting. She repeated that she had to force herself not to think she was different. She used her initiative and never thought that she was a foreigner, never guessed what the others thought about her. She considered there were many things in life that no one could measure in detail and say if it was equal or fair. She did not believe in the existence of fairness.

W5 had remarkable personal experiences and feelings regarding the relationships between love, marriage and family in Chinese and Scottish cultures. Love, marriage and family were considered a single event in Chinese culture but as different developmental stages in Scottish culture. She stated that they both felt uncomfortable with these different perceptions and had made many adjustments and compromises to make their marriage a successful one.

This was sometimes painful. She suffered from postnatal depression for quite a few months because her husband did not like her mother to come to assist her during and after her childbirth in the fear of her interference in their way of bringing up their own child. *Zuo yuezi* centre was first mentioned by her. By contrast the presence of her baby boy had linked her and her husband's family more closely than before.

The suggestion she made for improving maternity care was that the health workers should prepare themselves to be good listeners rather than educators.

W6

W6 had come to Edinburgh two years ago with her husband from a rural area near Hengzhou. Her husband is a Chinese doctoral student. They live in a shared two apartment flat with another couple in the centre of the city. The first two interviews took place in their bedroom. The woman had been a primary school teacher before she came to Britain. She speaks little English.

She appeared very friendly and outward going despite the fact that she was quite suspicious of those 'silly' questions on the food that she had during pregnancy in the first two interviews. She thought it was common sense that every Chinese should know. Some subtle but significant differences were noted in the response of W6 to questions compared with other urban Chinese women. An educated person from a rural environment appeared more cautious and suspicious whereas an urban person appeared more or less indifferent to what was going on.

She had very limited knowledge about health in general. Too much information was threatening for her. She felt more comfortable with as little information as possible concerning pregnancy and birth. She did not feel the need of

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collecting information on diet, nor the skills taught in antenatal classes. She had a healthy pregnancy and a medical delivery.

After the birth her husband took charge of everything at home because there were no parents or other relatives around to help out in this new land. He had to do the cooking, to answer all the phone and ensure that she could 'sit in' for a full month. He appeared to be a good responsible husband and father.

She was contacted five times over the phone in the month after her childbirth. Her husband answered all the calls and refused to put them through to her because she was sleeping or not available to answer any calls. She eventually answered the phone on the sixth attempt and stated that she was struggling with the care of her baby. Four months later the last two postnatal interviews were eventually arranged. She revealed in the interviews that they did not like to see any one during the sitting in period after the birth.

W7

W7 had come from Hong Kong to Britain nine years ago, met her husband and got married six months later. Her Chinese husband is a self-employed food supplier and she is a housewife. They had an eight year old son, when they were expecting their second baby. Her experience of the first childbirth was in Britain. All four interviews took place in their semi-detached house in the centre of the town. She has little English. She was very clever in house keeping. Her house was clean, well decorated and well organised.

W7 paid attention to avoid food of a cold nature during her pregnancy within what she could understand though her knowledge of food thermo-status was still quite patchy. She attended all antenatal check-ups but none of the antenatal classes because she could not understand them. She felt she had a good labour, without drugs or tears. She had no idea what a birthing plan was. She wanted her husband to be present at her birth but was not so sure whether he could be there or not because he was too busy with his own business. She was very pleased that her husband was present at her daughter's birth after all.

She introduced her sister-in-law to me, who is Scottish and was at the same stage of pregnancy as she. W7 had a normal spontaneous vertex delivery, no perineal tear and a good recovery. She did not adhere to the traditional rules of sitting in for the month and went out to do shopping a week after her childbirth. She did not bother too much about her postnatal diet on the basis that what she ate would not affect her baby anyway since the baby was bottle fed.

W8

W8 had come from Zhejiang with her husband, to London five years ago and then moved to Edinburgh three years ago. She had once worked as a language teacher and an interpreter for a bank in China before she came to Britain. Her husband was a research fellow. They lived in a two apartment flat in the centre of the town. The flat was basic but clean. All four interviews took place at their home.

She had an eight year old daughter born in China. W8 was an outward going person, happy to be a housewife and did not feel too much dependency, as long as husband handed her his salary each month which he mostly did.

She felt antenatal classes were boring. She attempted to understand her present situation and experience of the NHS health system on the basis of her past experiences in China, comparing them in terms of diet, antenatal care, giving birth, postnatal recovery and baby care. She had extraordinary trust in pharmaceutical treatment. She was confident in self diagnosing some hot and cold symptoms and applying some common diet remedies on her own.

She had a trouble free pregnancy and a straight forward delivery with assistance of drugs, amniotomy and perineal repair. She and her husband followed the traditional *zuo yuezi*, i.e. no contact with any cold water, not drinking too much water or having spicy food. They used hot water to avoid the irritant effect of cold water if she felt that she had to do some washing. She felt the amount of the hospital food was far from enough. She was reluctant to ask for boiled water instead of iced water, milk instead of tea or coffee. Asking for something different appeared to her to be requesting privileged treatment.

The suggestions she made for improving the maternity service was to have a choice of the sex of the baby so that she could have a boy. This reflects the male child preference especially after having had a girl first.

W9

W9 is a former forestry engineer in China who had come to Edinburgh to join her husband about two years ago. He is a PhD student. They live in a two apartment council flat in a deprived area in the city. One of the rooms was sublet to another Chinese student to ease their housing expenditure. It appeared that she had quite a lot of fear living in that area. She would not normally answer the door if she was alone at home, unless she knew who the visitor was. All interviews were conducted at her home.

The pregnancy was a surprise to her but the couple were happy to be having a child. W9 did not seek antenatal care and attend antenatal classes until she was over five months pregnant fearing that she might have to pay all maternity care expenditure. She felt she had a smooth pregnancy and a straight forward drug free, short labour. The couple was very pleased to have a girl because they thought a girl knew how to love her parents. She rarely took her baby out for a walk even three months after her birth; she went out only when she needed to do some shopping.

Her husband was busy with his study so she had to do most of the housework and look after the child herself. She could not follow the rules of *zuo yuezi* very well so she said that she had a lot of discomfort and pain in the joints of her hands, shoulders and feet.

Compared with the other women from mainland China, she had maintained more traditional Chinese customs and beliefs. For instance, her reluctance to have a bath and shampoo after the childbirth and her belief that the pain she had after the birth was due to the bath and contact she had with cold water. She tried to shape her baby girl's occipital area by placing a pillow and some books beside her head.

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W10

W10 had been a journalist before she married an Englishman seven years ago and became a housewife. She has a 15 year old daughter from her first marriage and a seven year old son by her present husband, who is a lecturer. She was very cautious and was unhappy to have the interview taped at her home but it was acceptable for the researcher to take notes. After about ten minutes, when she found that the questions asked were simple and general in nature, and she eventually agreed to let the interview be taped. The main focus of the interview with her was on *zuo yuezi* and postnatal diet.

She had a pregnancy complicated by antepartum haemorrhage and a medical delivery under epidural. Then she had a heavy immediate postpartum haemorrhage (PPH), became semi-conscious and had to receive eight units of blood transfusion. She said she had no idea what was the cause of this PPH, neither did the obstetric staff. She had to stay in the High Dependency Unit for two days and had a good recovery after the PPH was under control. The baby girl was fit and well. Her mother came from China and helped her with *zuo yuezi* for four weeks and left her when the nanny came.

W11

W11 had come to Britain from Shanghai eight years ago as a PhD student sponsored by the Chinese government. Her Chinese husband is a medical physicist also from Shanghai. They met in Britain and married five years ago. After she finished her degree study she got a job as a computer scientist, first in Dundee then in Glasgow. She lived in Edinburgh because her husband worked in Edinburgh. They have bought a three bedroom flat in the centre of the city.

She had a trouble free pregnancy and short medical delivery. Both her in-laws came a month before her baby girl was due to help her with *zuo yuezi*. She appeared to be happy to be the centre of the family and well looked after for the month. She did not have much knowledge of traditional customs and beliefs of childbearing, like the other women from mainland China in the study, but she stated that she had confidence in the practice of *zuo yuezi* and the modification of the postnatal diet. She adhered to the rules of *zuo yuezi* strictly, for instance, staying in for a month, no visitors to her home for the month, etc.

W12

W12 is from Shanghai and had a research post in Switzerland. She married a German before she came to Britain to study and separated from her husband. This was her first baby. The father of this baby was a British lecturer. She was contacted by the researcher when she was in her 34th week of gestation. She was reluctant at first but eventually agreed to be interviewed after her childbirth because she was too busy with her work.

She was contacted again by phone on her expected date of delivery and the interviews were arranged. The interviews took place at her partner's flat in the centre of the town. Two antenatal interviews were conducted retrospectively as well. She had her son by caesarean section two weeks before due to early rupture of membrane and absence of contractions after induction of labour. She was typical in a way that like the other participants in this study she did not have much knowledge of Chinese traditional custom of childbearing and had her reservation and doubts about them. She was not typical in that she had freed herself from the Chinese restrictions on sex, marriage and family through her academic work and contacts with some current western ideas.

Scottish women

Wa

Wa is married to a doctor. They live in a new modern second floor 2 bedroom flat. She volunteered to be the first participant. She appeared frank and secure. She had a miscarriage before this birth. Wa had a positive attitude to pregnancy and active preparation for a normal childbirth. To her disappointment her labour failed to progress due to cephalo-pelvic disproportion and she had to have an emergency caesarean section. But she refused to have a pelvimetry done after the childbirth. She appeared very self-confident but a sense of insecure feeling and doubts was conveyed through what she had gone through during the labour. This deep uncertainty came to the surface when she kept on asking what the researcher thought and what she would do if she was in her situation.

It seemed she was quite content staying at home and looking after her baby, if financially feasible. She had a very intense antenatal preparation but it turned out that she had for her a negative outcome. She presented herself in a way as a typical middle class - articulate, assertive and self-confident.

Wb

Wb became a full-time housewife after her maternity leave having been a staff nurse before. Her husband was an engineer. All four interviews were carried out at the woman's home and one follow-up in the hospital. She moved into a three-bedroom newly reconverted farm house with new carpet and curtains just a couple of months before the first interview.

Apart from the routine four interviews, an informal interview was conducted in the postnatal ward on the postnatal day 5. Wb had experienced peaceful pregnancy but a difficult labour with medical and surgical interventions, such as amniotomy, augmentation with intravenous syntocinon, diamorphine, epidural, an episiotomy and forceps delivery. She had everything that she did not want in her plan. She appeared very disappointed about the inability to make the right choice and went along with what the midwife said. The baby was in occipitoposterior position (OP) and then had meconium stained developed because of the prolonged second stage of labour and the application of intravenous syntocinon. He had to be delivered by forceps delivery and then had some difficulty with shoulder delivery too. Wb seems to have experienced the cascade of interventions (Ch 9).

She felt that she was treated differently because she was a member of staff in the hospital. She was left alone on her own ward away from the other mothers. She felt it was good to have her own room but in a way it prevented her from

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having other people round to ask them for some help. She did not think she could get better care than the others. The first month was fine for her because her husband got a month leave to help out postnatally, but the care of her baby was a shock to her system after that.

Wc

Wc had participated in the pilot study of this project when she had her first baby boy 18 months ago. She had a healthy second pregnancy. She had presented herself in a well constructed way in family building, smoking and drinking, the relation between children and mother, doctor and midwife, doctor and patients.

In her first pregnancy and birth she had an easy time up to two hours before the end of the second stage then the labour failed to progress and eventually she ended up with an Ventouse extraction. She felt she was not prepared for the pain and Ventouse extraction she went through. She was quite disappointed that she had planned to have drugs for pain but she received nothing because her labour was thought to be progressing extremely well. She had planned not to have an episiotomy and intervention but she had them both. The midwife asked her to try gas and air for more than an hour but later her partner discovered the cylinder was actually empty. It turned out that she had practically a drug free delivery. She had two requests in her birth plan: first, she did not want an episiotomy and secondly, she would like to have analgesia. Neither request has been met. She had an episiotomy and did not have any drugs. She thought her birth plan was useless.

She felt that she was poorly informed by the medical staff and they did not see any part of their job to explain anything to her except make sure medically that she and her baby were safe. Once the doctors came in, the midwives adopted a secondary role and let the technology take over. She thought she had a 'horrible' birthing experience. She probably would be quite 'scared' about labour next time round had she not been cared for in her first labour. She felt that she would be much keener to accept drugs quicker even she felt uncomfortable to ask for them on the basis of being afraid. Based on her previous experience she felt that she could not see the value of making a birth plan again because the circumstances change from one minute to another. She also suggested that to be able make a right choice for one's birth plan did not come down to information but to the behaviour of the baby, which was unpredictable. According to her, prior information gave people more sense of control but it did not actually give any sense of ultimate control because the actual control would be as it turns out.

She had a good pregnancy and uncomplicated straight forward delivery with her second child. She had a baby girl with some help of entonox. The whole labour lasted about five hours.

Wd

Wd was born in Musselburgh, Edinburgh and married to a food supplier from Hong Kong five years ago. She had a four year old daughter. She was introduced to the researcher by her sister-in-law, who (W7) was one of the Chinese participants in the study. Their brothers and their mother-in-law's families lived just a couple of doors away from each other. Their relationship appeared harmonious. She was first interviewed when she was in her 30th week of pregnancy. All four interviews took place in the woman's home.

She had an easy pregnancy and a drug free labour, though the labour was longer than she expected. She felt that with her husband present this time she could cope with it. Wd raised interesting points. The family network around her was thought to be her in-law's family, her own family and her friends. Her attitude towards woman's place and man's place at home was distinct. She thought they should be equal. She said 'If man wants something for dinner, he is in himself and he cooks himself'. She wanted her children to know how to use the cooker, how to use washing-machine, and other household equipment so that they could take care of themselves, if they have to.

Her experience as a Chinese's wife could be difficult for her at times. Her mother-in-law always complained that she did not make meals for her husband and her house was never clean enough. Her mother-in-law always came to check and help her to take the rubbish away. She always brought some soups to her son but never for her daughter-in-law. Her husband was close to her and her daughter even though her daughter 'did not feel much for him', because she usually went to bed by the time he came back.

Though her husband is a Chinese, she did not feel any difference. She got along with her husband very well, but not with her mother-in-law. Her mother-in-law always thought she was no good at house keeping. Every time when she brought some food for her son and saw her grand daughter, she helped empty the dust bin and made sure the rubbish was out properly ready for collection. Mother-in-law and daughter-in-law usually communicated by gesture. They managed to understand each other well though they did not visit each other very often. When Wd needed someone to look after her daughter, she usually took her to her own mother first, perhaps, sometimes, her mother-in-law.

We

We had just finished her own PhD in anthropology and had a two hours a week casual teaching post in Edinburgh. She had a good pregnancy though her haemoglobin level (10) was on the low side. Though she had a non-intervention delivery, she developed anaemia and was put on iron after labour. She raised a problem in the relationship between her career and having children.

She thought having a family was to make marriage complete though people around her thought she was to sacrifice her career to have a child and make her feel their contempt. She regretted not to have had a baby earlier. Anyway she tried not to lose her privilege of employment after completion of her PhD.

She had a boy after a straight forward normal delivery. She thought it was nice that her boy can carry on her husband's last name. She suggested that the basic knowledge and care of the new-born should have been included in antenatal classes. She also expressed her uncomfortable feeling towards the way people treated her as if she was a foreigner simply because that she was brought up in America.

Appendix IX

Wf

Wf was first interviewed when she attended the antenatal clinic at her 34 weeks antenatal check-up. She was having her first baby. Her mood appeared to be low and she was rather reluctant to answer the question on her relation with her husband in the first interview.

The second interview was carried out in her first floor flat in the centre of the city. The flat looked clean but very damp and basic. She appeared content and quiet. She had a good pregnancy with no morning sickness and no other discomfort and induction of labour under epidural. She has a full term baby boy. Her whole labour lasted 12 hours. Her mother came to stay with her for the first week after the birth of their son.

Wg

Wg was a primigravida though she had two miscarriages. All interviews took place in the woman's house. She thought attending antenatal classes was a waste of her time. She preferred to read for herself. The only regret for not attending classes was that she did not feel that she was well prepared to deal with the problems associated with breast feeding. The choice of food was based on what looked good and economical when she was doing her shopping. Her choice of food was based on calories and protein.

She did not feel the need of having a birth plan because of the unpredictability of the labour. She said she might regret later when she had her baby but she would like to see what would happen first. Eventually she did make a birth plan. She had a spontaneous vertex delivery with some pain relief of diamorphine. The only thing she put down in her birth plan was not to have amniotomy but unfortunately she had it soon after admission when her cervix was six centimetre dilated. She requested an early discharge and went home on day three but had to return to hospital on day four because of breast feeding problems, a dehydrated baby and engorged breasts. On her second admission she developed pyrexia. The only complaint she had was her midwife made her to have her shower first after the childbirth without tea and toast. She felt that she was nearly faint during the shower because she was so hungry.

Wh

Wh was introduced to the researcher by her mother, who was an auxiliary nurse. All four interviews took place in the sitting room of the woman's home. This was her first pregnancy. They moved in to a two-bedroom semi-detached council house in a very small beautiful town in East Lothian before their baby's birth and put their own flat on the market. The house appeared clean, basic but comfortable with some old furniture.

She felt that her pregnancy was fine apart from having some symptoms of glycosuria and slight oedema of the low extremities. She had an emergency caesarean section due to fetal distress but had a good recovery after the operation. Her mother and her husband were present during the birth. Her mother was so upset by what she went through that she felt unwell for the following three weeks. The symptoms of glycosuria and oedema disappeared without any medical treatment soon after her childbirth.

She took the advice from her mother and started to feed her baby custard when he was three week old. She chose not to attend any antenatal classes because she thought she could read anything that she wanted to know from books, reference leaflets and from watching TV. She never bothered her self to eat more vegetables and fruit because they were not in her usual diet. However she decided to eat some more brown bread. She had a section because of fetal distress.

Wj

This is Wj's first pregnancy and first childbirth though she had a step son from her husband's first marriage. They lived in a nice and comfortable house on the outskirts of Edinburgh. She appeared to be an articulate and conscientious ladies. She tried to remain an active life style during her pregnancy. Her perception of a normal childbirth was a vaginal birth with some assistance of drugs, breathing exercises, and TENS. She enjoyed having a high fibre, protein and low fat healthy diet and also enjoyed attending the antenatal clinic and antenatal classes. Apart from this she also attended NCT classes. She felt there were some differences between these two. The NHS's approach was more structured and down to earth and NCT's was more ideological.

She had a normal delivery despite the obstetric advice and encouragement of having analgesia and acceptance of forceps or caesarean section. Both her husband and herself was delighted to have their baby girl. The food they have in the first month postnatally was prepared and freezed a month before the birth of their child. She tried to mobilise herself in the house soon after hospital discharge.

Wk

Wk married a Turkish food specialist 23 years ago. She met her husband in Glasgow University when he was doing his postgraduate study on food. Both of them stayed there for eight years then they decided to go back to Turkish to run a business there.

They have a house in Edinburgh and another house in Turkey. Both of them travel between these two places spending the summer in Turkey and winter in Edinburgh. They had been trying to have a family for years and eventually she conceived by IVF. Their IVF was done as a private patient in Aberdeen last year when it was discovered that they were having twins. The pregnancy had been safe and sound though she had some bleeding in the first month.

Her sister-in-law came to stay with the couple a month before their booked section and stay with them six month postnatally. Her sister-in-law was an unmarried young woman, very good at cooking and house keeping. Wk and her sister-in-law took their turn to look the twin brothers while her husband was at work.

Prior the birth of their twin boys her husband expressed his strong wishes of having a son to carry on his family name and was delighted to know from ultra sound scan that they were going to have at least one male child. Wk did not show much enthusiasm on the sex of the baby comparing to her husband.